



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

This historical compilation on the Social Security Act and Amendments is provided specifically for the position of:

Department Library

These volumes are not to be considered personal possessions of the incumbent and remain the property of the United States Government.

KP
3643.6
.R47
1970
v.2

REPORTS BOOK

1935-69

Volumes 1-4

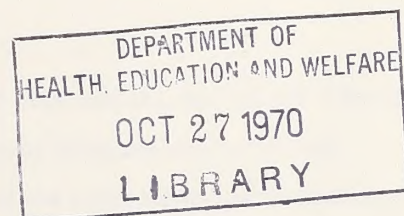
74th-91st CONGRESSES

COMMITTEE ON ECONOMIC SECURITY

ADVISORY COUNCILS

AND

OTHER SELECT REPORTS, STUDIES, AND PRESIDENTIAL
MESSAGES RELATING TO THE SOCIAL SECURITY ACT



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

REPORTS BOOK
TABLE OF CONTENTS

VOLUME 1

I. COMMITTEE ON ECONOMIC SECURITY

- A. Report to the President of the Committee on Economic Security--*January 15, 1935*
- B. Supplemental Statements to the Report of the Advisory Council to the Committee on Economic Security--*December 15, 1934*
- C. Report of the Advisory Council to the Committee on Economic Security--*December 18, 1934*
- D. Supplement to Report to the President of the Committee on Economic Security--*1935*
- E. Message from the President of the United States Transmitting a Report of the Committee on Economic Security, H. Document No. 110--*January 16, 1939*

II. ADVISORY COUNCILS

A. Social Security

- 1. Advisory Council on Social Security, Final Report, S. Document No. 4--*January 5, 1939*
- 2. Recommendations for Social Security Legislation, the Reports of the Advisory Council on Social Security to the Senate Committee on Finance--*June 19, 1948*
- 3. Financing Old-Age, Survivors, and Disability Insurance, A Report of the Advisory Council on Social Security Financing--*January 1, 1959*
- 4. The Status of the Social Security Program and Recommendations for Its Improvement, Report of the Advisory Council on Social Security--*January 1, 1965*
- 5. Health Insurance for the Disabled, A Report of the Advisory Council--*December 31, 1968*
- 6. Annual Report on Medicare, covering the period *July 1, 1966–December 31, 1967*,
A Report of the Health Insurance Benefits Advisory Council--*July 1969*

B. Public Welfare

Having the Power, We have the Duty, Report to the Secretary of Health, Education, and Welfare--*June 29, 1966*

VOLUME 2

III. SELECT REPORTS AND STUDIES RELATING TO THE SOCIAL SECURITY PROGRAM

A. Disability--Committee on Ways and Means (Harrison Subcommittee)--1959–60

- 1. Disability Insurance Fact Book, A Summary of the Legislative and Administrative Development of the Disability Provisions in Title II of the Social Security Act, Prepared by the Staff of the Subcommittee on the Administration of the Social Security Laws for the Use of the Committee on Ways and Means--*1959*
- 2. Sample Disability Survey, prepared by Personnel of the General Accounting Office under Direction of the Subcommittee Staff, at the request of the Subcommittee on Administration of the Social Security Laws of the Ways and Means Committee, House of Representatives--*December 1959–January 1960*

TABLE OF CONTENTS *(Continued)*

VOLUME 2 *(Continued)*

3. Administration of the Social Security Disability Insurance Program, Preliminary Report to the Committee on Ways and Means, Submitted by the Subcommittee on the Administration of the Social Security Laws, Committee Print--*March 11, 1960*

B. Extension of Coverage

1. The Extension of Old-Age and Survivors Insurance to Agricultural and Domestic Service Workers and to the Self-Employed. Division of Tax Research, Treasury Department--*November 1947*
2. Digest of Issues in Social Security. A digest of the Report Submitted in January 1946 to the Committee on Ways and Means, House of Representatives, by the Technical Staff, Established Pursuant to H. Res. 204, 79th Congress, 1st session, with Statistical Revisions and References to Subsequent Developments--Senate Committee Print--*November 7, 1947*
3. A Report to the Secretary of Health, Education, and Welfare on Extension of Old-Age and Survivors Insurance to Additional Groups of Current Workers, Consultants on Social Security--*June 24, 1953*
4. Message from the President of the United States Recommending a Definite Plan for Making our Social Security Programs More Effective--*August 1, 1953*
5. Inclusion of Income Derived from Tips and Gratuities for Purposes of Coverage Under Old-Age, Survivors, and Disability Insurance Programs, A Report by the Department of Health, Education, and Welfare on a Study Called for by the Committee on Ways and Means in Compliance with H. Report No. 2288, 85th Congress, 2d session--*April 5, 1960*
6. Coverage of Federal-Civilians
 - (a) Social Security and Federal Employment, A Report Requested by the Committee on Ways and Means, Submitted by the United States Civil Service Commission and the Social Security Administration, Department of Health, Education, and Welfare--Committee Print--*March 13, 1965*
 - (b) Message from the President of the United States transmitting the Joint Annual Report of the Director of the Bureau of the Budget and the Chairman of the Civil Service Commission and the Report of the Cabinet Committee on Federal Staff Retirement Systems--H. Document No. 402--*March 7, 1966*
 - (c) Relating Social Security Protection to the Federal Civil Service, A Report Requested by the Committee on Ways and Means and the Committee on Finance. (Pursuant to Public Law 90-248, the Social Security Amendments of 1967)--*January 1969*

C. Retirement Test

1. The Retirement Test Under Old-Age and Survivors Insurance, A Report and a Supplementary Report on a Study Called for by the Committee on Ways and Means, in H. Report 2288, 85th Congress, Submitted by the Secretary of Health, Education, and Welfare. Committee Print--*March 29, 1960*

TABLE OF CONTENTS *(Continued)*

VOLUME 2 *(Continued)*

2. The Retirement Test Under Social Security, A Report Resulting from a Study of the Retirement Test Pursuant to Public Law 90-248, the Social Security Amendments of 1967, Submitted by the Secretary of Health, Education, and Welfare. H. Document 91-40--
January 9, 1969

D. Minimum Benefit

The Minimum Benefit Under Old-Age and Survivors Insurance, A Report on a Study Called for by Public Law 761, 83d Congress, Department of Health, Education, and Welfare--1955

VOLUME 3

E. Health Care for the Aged

1. Health Insurance for Aged Persons, Report Submitted to the Committee on Ways and Means, House of Representatives, by the Secretary of Health, Education, and Welfare--*July 24, 1961*
2. Hospitalization Insurance for Old-Age, Survivors and Disability Insurance Beneficiaries, Report Submitted to the Committee on Ways and Means by the Secretary of Health, Education, and Welfare in Compliance with H. Report No. 2288, 85th Congress. Committee Print--
April 3, 1959
3. The Health Care of the Aged, Background Facts Relating to the Financing Problem, Department of Health, Education, and Welfare, Social Security Administration, Division of Program Research--1962
4. A National Program for Financing Health Care of the Aged, Guiding Principles for Complementary Public and Private Action, A Report to the American Public from the National Committee on Health Care of the Aged--*November 1963*
5. A Report to the President on Medical Care Prices by the Department of Health, Education, and Welfare--*February 28, 1967*
6. Reimbursement Incentives for Hospital and Medical Care, Objectives and Alternatives. Department of Health, Education, and Welfare, Social Security Administration--*March 1968*
7. Annual Reports on the Medicare Program--1968-1969

First Annual Report, pursuant to Section 1875(b) of the Social Security Act, transmitted by the Secretary of Health, Education, and Welfare. H. Document No. 331, 90th Congress, 2d session--*June 24, 1968*

Second Annual Report, pursuant to Section 1875(a) and (b) of the Social Security Act, transmitted by the Secretary of Health, Education, and Welfare. H. Document No. 91-57, 91st Congress, 1st session--*January 20, 1969*
8. Health In America: The Role of the Federal Government in Bringing High Quality Care to All the American People--Department of Health, Education, and Welfare (See IV K)--1968
9. Independent Practitioners Under Medicare, A Report to the Congress (Pursuant to Public Law 90-248, the Social Security Amendments of 1967)--*December 1968*

TABLE OF CONTENTS (*Continued*)

VOLUME 4

E. Health Care for the Aged (*Continued*)

10. Feasibility Study on Preventive Services and Health Education for Medicare Recipients, A Report to the Congress (Pursuant to Public Law 90-248, the Social Security Amendments of 1967)--*December 1968*
11. Financing Care of Mentally Ill Under Medicare and Medicaid (Interim Report), A Report to the House Committee on Ways and Means and the Senate Committee on Finance (Pursuant to Public Law 90-248, the Social Security Amendments of 1967)--*December 1968*
12. Personnel Qualifications for Medicare Personnel, A Report to the Congress (Pursuant to Public Law 90-248, the Social Security Amendments of 1967)--*December 1968*
13. Task Force on Prescription Drugs, Reports and Recommendations, Prepared by the Department of Health, Education, and Welfare--*1968-1969*
Final Report--February 7, 1969
Background Papers--February 1969
Third Interim Report, The Findings of the Department of Health, Education, and Welfare with Respect to the Coverage of Drugs under Part B of Title XVIII of the Social Security Act. H. Document 91-43, 91st Congress, 1st session--January 14, 1969
14. Payment of Medicare Benefits in Neighboring Nations: Problems and Possible Approaches (Interim Report), A Report to the Congress (pursuant to Public Law 90-248, the Social Security Amendments of 1967)--*June 1969*

PUBLICATIONS

Attitudes Toward Governmental Participation in Medical Care by Wilbur J. Cohen, Charles N. Poskanzer and Harry Sharp, Reprinted from *Health Needs of the Aged and Aging*, Hearings before the Subcommittee on Problems of the Aged and Aging, Senate Committee on Labor and Public Welfare--*April 1960*

Public Welfare Amendments of 1962 and Proposals for Health Insurance for the Aged by Wilbur J. Cohen and Robert M. Ball--*Social Security Bulletin--October 1962*

Medical Care Price Changes in Medicare's First Two Years, by Dorothy P. Rice and Loucele A. Horowitz--*Social Security Bulletin--November 1968*

Utilization and Cost of General Hospital Care: Canada and the United States, 1948-66, by Louis S. Reed and Willine Care--*November 1968*

IV. SELECT PRESIDENTIAL MESSAGES RELATING TO HEALTH CARE

¹A. Health Security, Message from the President of the United States (Franklin D. Roosevelt). H. Document 120, 76th Congress, 1st session--*January 23, 1939*

B. National Health Program, Message from the President of the United States (Harry S. Truman). H. Document 380, 79th Congress, 1st session--*November 19, 1945*

¹Including the Report and Recommendations on National Health by the Interdepartmental Committee to Coordinate Health and Welfare Activities and the Report on A National Health Program: Report of the Technical Committee on Medical Care.

TABLE OF CONTENTS *(Continued)*

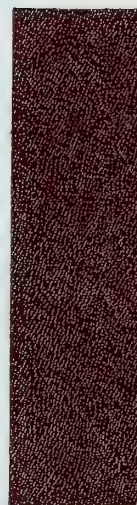
VOLUME 4 *(Continued)*

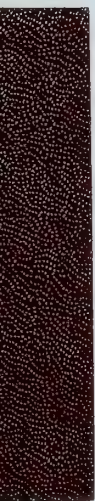
- C. National Health and Disability Insurance Program, Message from the President of the United States (Harry S. Truman). H. Document 261, 80th Congress, 1st session--*May 16, 1947*
- D. The Nation's Health Needs, Message from the President of the United States (Harry S. Truman). S. Document 59, 81st Congress, 1st session--*April 22, 1949*
- E. Health Program, Message from the President of the United States (John F. Kennedy). H. Document No. 85, 87th Congress, 1st session--*February 9, 1961*
- F. Health Program, Message from the President of the United States (John F. Kennedy). H. Document No. 347, 87th Congress, 2d session--*February 27, 1962*
- G. Health Program, Message from the President of the United States (John F. Kennedy). H. Document No. 60, 88th Congress, 1st session--*February 7, 1963*
- H. Elderly Citizens of Our Nation, Message from the President of the United States (John F. Kennedy). H. Document No. 72, 88th Congress, 1st session--*February 21, 1963*
- I. Health of the Nation, Message from the President of the United States (Lyndon B. Johnson). H. Document No. 224, 88th Congress, 2d session--*February 10, 1964*
- J. Advancing the Nation's Health, Message from the President of the United States (Lyndon B. Johnson). H. Document No. 44, 89th Congress, 1st session--*January 7, 1965*
- K. Health in America, Message from the President of the United States (Lyndon B. Johnson). H. Document No. 270, 90th Congress, 2d session (See III E 7)--*March 4, 1968*

V. OTHER SELECT REPORTS AND STUDIES

- A. Old-Age Pension System, Preliminary Report of the Special Committee to Investigate the Old-Age Pension System Pursuant to S. Resolution No. 129 (77th Congress), S. Report No. 666--*August 28, 1941*
- B. Pensions in the United States, A Study Prepared for the Joint Committee on the Economic Report by the National Planning Association--*December 19, 1952*
- C. Social Security After 18 Years, A Staff Report to Hon. Carl T. Curtis, Chairman Subcommittee on Social Security for the Committee on Ways and Means, House of Representatives, 83d Congress, 2d session--*1954*
- D. Social Security After 18 Years, Statement of the Democratic Members of the Subcommittee on Social Security of the Committee on Ways and Means for Release Concurrently with the Issuance of the Report of the Staff to the Chairman of the Subcommittee on Social Security, 83d Congress, 2d session--*1955*
- E. Public Policy and Private Pension Programs, A Report to the President on Private Employee Retirement Plans, by President's Committee on Corporate Pension Funds and Other Private Retirement and Welfare Programs--*January 1965*

Listing of Reference Materials





DISABILITY INSURANCE FACT BOOK

A SUMMARY OF THE LEGISLATIVE AND ADMINISTRATIVE DEVELOPMENT OF THE DISABILITY PROVISIONS IN TITLE II OF THE SOCIAL SECURITY ACT

PREPARED BY THE STAFF OF THE
SUBCOMMITTEE ON THE ADMINISTRATION OF
THE SOCIAL SECURITY LAWS FOR THE USE OF
THE COMMITTEE ON WAYS AND MEANS



NOTE.—The printing of this subcommittee staff document has been authorized by the Committee on Ways and Means in accordance with its rules of procedure so as to make it available for informational purposes. Its contents have not been substantively considered by the committee membership, and hence it has neither been approved nor disapproved by the full committee.

COMMITTEE ON WAYS AND MEANS

WILBUR D. MILLS, Arkansas, *Chairman*

AIME J. FORAND, Rhode Island	RICHARD M. SIMPSON, Pennsylvania
CECIL R. KING, California	NOAH M. MASON, Illinois
THOMAS J. O'BRIEN, Illinois	JOHN W. BYRNES, Wisconsin
HALE BOGGS, Louisiana	HOWARD H. BAKER, Tennessee
EUGENE J. KEOGH, New York	THOMAS B. CURTIS, Missouri
BURR P. HARRISON, Virginia	VICTOR A. KNOX, Michigan
FRANK M. KARSTEN, Missouri	JAMES B. UTT, California
A. S. HERLONG, JR., Florida	JACKSON E. BETTS, Ohio
FRANK IKARD, Texas	BRUCE ALGER, Texas
THADDEUS M. MACHROWICZ, Michigan	ALBERT H. BOSCH, New York
JAMES B. FRAZIER, JR., Tennessee	
WILLIAM J. GREEN, JR., Pennsylvania	
JOHN C. WATTS, Kentucky	
LEE METCALF, Montana	

LEO H. IRWIN, *Chief Counsel*

JOHN M. MARTIN, JR., *Assistant Chief Counsel*

THOMAS A. MARTIN, *Minority Counsel*

GERARD M. BRANNON, *Professional Staff*

SUBCOMMITTEE ON ADMINISTRATION OF THE SOCIAL SECURITY LAWS

BURR P. HARRISON, Virginia, *Chairman*

A. S. HERLONG, JR., Florida	THOMAS B. CURTIS, Missouri
WILLIAM J. GREEN, JR., Pennsylvania	JACKSON E. BETTS, Ohio
JOHN C. WATTS, Kentucky	ALBERT H. BOSCH, New York
LEE METCALF, Montana	

FREDERICK B. ARNER, *Subcommittee Counsel*

INTRODUCTION BY THE CHAIRMAN OF THE SUBCOMMITTEE

As its first subject of inquiry the Subcommittee on the Administration of the Social Security Laws has chosen the disability insurance provisions of title II of the Social Security Act. In the initial stages of the study it became apparent that there was a need for development and consolidation of the factual information which was available on the disability program. It was decided, therefore, that the staff of the subcommittee would, in collaboration with operating officials of the Department of Health, Education, and Welfare, prepare a basic fact book which would pull together the many facets of the program and serve as a ready reference guide for subcommittee members during their more detailed examination of the administration of the disability law.

It is emphasized that this book, in no way, should be interpreted as a part of the legislative history of the disability provisions. The function of this fact book is neither to sanction nor question. The material presented is that which has been made available by the Department for the initial briefing of the members of the subcommittee. It should not, therefore, be considered as the subcommittee's ultimate conclusion as to the nature of the administration of the disability provisions.

Part I of the fact book is a brief thumbnail sketch of the disability program which attempts to highlight the areas which are most likely to be of subcommittee concern. Appropriate references are made in this short summary to the detailed information and statistical data in parts II through XI of the fact book which were prepared by the Social Security Administration.

The subcommittee wishes to give a full measure of recognition to and to express appreciation for the services of the staff of the Social Security Administration, particularly the Bureau of Old Age and Survivors Insurance, in preparing the materials which form the basis for this analysis of the operation of the disability program. The subcommittee also wishes to thank the Department of Health, Education, and Welfare for its cooperation in making these services available.

BURR P. HARRISON.

CONTENTS

Part I. Brief summary of the disability program:	Page
Scope of the legislation.....	1
Eligibility requirements.....	1-2
The definition.....	2-4
Method of determining disability.....	4
Review of determinations.....	4
Right of administrative appeal.....	4-5
Appeal to the courts.....	5-6
Rehabilitation.....	6
Cost of the program.....	6-7
Part II. The development of the disability program under old-age and survivors insurance, 1935-58:	
Considerations of disability insurance, 1935-39.....	8-9
Considerations of disability insurance, 1940-50.....	9-10
Social Security Act Amendments of 1950.....	11-12
Social Security Act Amendments of 1952.....	12-13
Social Security Amendments of 1954.....	13-14
Social Security Amendments of 1956.....	14-16
Amendments to the Social Security Act in 1957.....	16
Social Security Amendments of 1958.....	16-17
Part III. The development of interpretive materials for determining disability under the Social Security Act:	
The law.....	18
Congressional committee reports.....	18-19
Regulations interpreting "disability".....	19-20
The Disability Insurance State Manual.....	20-21
Definition of "Disability":	
Inability to engage in substantial gainful activity.....	21-22
Medically determinable.....	22
Expected to be of long-continued and indefinite duration or to result in death.....	22
Remediable condition.....	22
Evidence of disability.....	22-23
Effect of determination of disability made by another agency.....	23
Disability evaluation guides.....	23-24
Medical factors in evaluating disability.....	24
1. Musculoskeletal system.....	24-25
2. Special sense organs.....	25
3. Respiratory impairments.....	26-27
4. Cardiovascular system.....	27-29
5. Digestive system.....	29
6. Genito-urinary system.....	29
7. Hemic and lymphatic system (blood and lymph).....	30
8. Endocrine system.....	30
9. Brain and nervous system.....	30-32
Other factors in evaluating disability.....	32
Age.....	32
Education.....	33
Experience.....	33
Effect of retraining or rehabilitation.....	33
Work to detriment.....	33
Substantial gainful activity.....	33-34

Part IV. Disability operating experience: Statistics and summary:	
Summary of selected workload and benefit data on disability operations.....	Page 35-36
Disability operating experience:	
1. General.....	37
2. Preparing for disability operations in the States.....	38
3. Disabilities covered by State agreements.....	38
4. Experience under the 1954 amendments.....	38-39
5. Experience under the 1956 amendments.....	39-40
6. Experience under the 1958 amendments.....	40-41
7. Processing time for disability cases.....	41
8. Development of evidence additional to that initially submitted.....	41-42
9. Techniques for review and control of administration in the disability operation.....	42-43
10. Financial aspects of disability operations in State agencies.....	43-44
Part V. Outline of disability claims process and rehabilitation referral:	
Filing application in Bureau of Old-Age and Survivors' Insurance district office.....	45
District office role in obtaining medical evidence.....	45-46
Forwarding claims.....	46
Responsibility of State agencies.....	46-47
Examination of State agency determination and authorization of payment.....	47-48
Determining continuance or cessation of disability.....	48
Disability freeze determinations for career railroad workers.....	48-50
Referrals for rehabilitation services and acceptance of such services by claimants.....	50-51
Part VI. Administrative appeals and court cases:	
Reconsideration.....	52
Hearings.....	53
Appeals Council review.....	53
Court review.....	54
Appeals experience.....	54
Workload—Reconsiderations and hearings.....	54-55
Referee staffing in relation to disability program.....	56
Results of actions taken on reconsideration.....	56-57
Results of actions taken on hearing.....	57
Requests for Appeals Council review.....	57-58
Court actions.....	58
Summaries of court decisions in disability cases.....	58-59
Affirmations.....	59-66
Reversals.....	66-71
Court dismissals (other than after favorable decision on remand to Department).....	72
Decisions favorable to plaintiff rendered by Department after remand from district court.....	72-73
Cases remanded on Court's motion or at plaintiff's request still pending before the Department.....	73
Part VII. Organizational structure for the administration of the disability program.....	81-84
Attachments.....	85
List of members, Medical Advisory Committee.....	85
List of members and technical consultants, States Council Committee on OASI Relationships.....	86
Model agreement with State agencies.....	86-91
Listing of State agencies and officials.....	91-93
Listing of officials of Department of Health, Education, and Welfare.....	94
Part VIII. Basic assumptions for actuarial cost estimates of disability benefits and analysis of current experience.....	98-101
Part IX. Summary of statutory provisions under title II of the Social Security Act relating to disability:	
Disability insurance benefits:	
Conditions of entitlement.....	102
Definition of "insured," "disability" and "waiting period".....	102
Benefits of dependents of disability insurance beneficiary.....	102-103
Funds from which benefits are paid.....	103

CONTENTS

VII

Part IX. Summary of statutory provisions under title II—Continued	Page
Period of disability ("freeze").....	103
Conditions for establishing a period of disability.....	103
Definitions.....	103
Beginning and ending of periods of disability.....	104
Effect of period of disability.....	104
Insured status.....	104
Protection of benefit level.....	104
Childhood disability benefits.....	105
Eligibility to benefits.....	105
Definitions of disability and dependency.....	105
Funds from which benefits are paid.....	105
Authority to make determinations of disability.....	105
Rehabilitation.....	106
Part X. General statistical information on disability insurance program:	
State agency operations.....	107-122
Denial rates: April-June 1959 and July-September 1958.....	107-110
Bureau review of determinations.....	110-116
Agency staffing and costs.....	117-122
Case processing time.....	123-126
Vocational rehabilitation.....	126-147
Rehabilitation of disability applicants by State agencies.....	126-136
Disability applicants considered for services by State agencies.....	137-147
Summary of selected data on disability operations.....	148
Initial applications: Allowances and denials.....	148-149
Reconsideration and hearing cases.....	149-150
Continuing disability cases.....	151
Pending workloads.....	152
Summary benefit data.....	153-158
Monthly data.....	153-155
Fiscal year data.....	156-158
Characteristics of disability applicants.....	159
Continuing disability experience: Cessations of periods of disability, 1958.....	190-205
General.....	190
Case Characteristics.....	190-205
Purchase of medical consultative examinations.....	206-211
Part XI. Summary of other disability programs:	
Veterans' Administration.....	212
Definition of disability.....	212
1. Pension.....	213
2. Compensation.....	213-214
3. Insurance.....	214
Administration.....	214
1. Determination of disability.....	214-215
a. Pension and compensation.....	214-215
b. Insurance.....	215
2. Appeals process.....	215-216
Railroad Retirement Act.....	216
Definition of disability.....	216-217
Administration.....	217
1. Determination of disability.....	217-218
2. Appeals process.....	218
Civil Service Retirement Act.....	218
Definition of disability.....	218-219
Administration.....	219
1. Determination of disability.....	219
2. Appeals process.....	219-220

TABLES AND CHARTS

Chart A—Hearing requests and examiners on duty.....	80
Chart B—Organization, Social Security Administration.....	95
Chart C—Bureau of Old-Age and Survivors Insurance.....	96
Chart D—Office of Hearings and Appeals organization chart.....	97
Table A—Workload data—Reconsiderations and hearings, 1947 through May 31, 1959.....	74-75

	Page
Table B—Actions on reconsideration, 1947 through March 31, 1959-----	76
Table C—Actions on hearings, 1947 through March 31, 1959-----	77
Table D—Civil court actions, 1940 through March 31, 1959-----	78
Table E—Analysis of hearing requests, disability and all others—August 1955 to May 1959-----	79-80
Table F—Comparison of actual and estimated experience under disability insurance program under provisions of 1956 act, 1957-58-----	100
Table G—Comparison of actual and estimated experience under disability insurance program under provisions of 1958 act, 1958-59-----	101
Table H—Number of State disability determinations effectuated in Bureau, April-June 1959, and number and percent denied by State--	108-109
Table I—State denial rates: Number and percent of jurisdictions by disability denial rate, July-September 1958 and April-June 1959-----	110
Table J—Number of State agency determinations initially reviewed in fiscal year 1959, and number and percent of cases questioned for substantive reasons by calendar quarter and type of State agency finding--	112
Table K—State determinations initially reviewed during April-June 1959: Number and percent questioned for substantive reasons by type of State agency finding-----	113-114
Table L—Number of State agency allowances questioned and number and percent eventually denied; number of State agency denials questioned and number and percent eventually allowed-----	115-116
Table M—Funds advanced to State agencies and end of year full-time personnel on disability work, by fiscal year-----	117
Table N—Amount and percentage distribution of expenditures by State agencies, by object classes, during July 1, 1958-June 30, 1959, period--	118
Table O—Jurisdiction of cases involving substantive disability determinations, calendar years 1955-58, inclusive, by year and first 6 months of 1959-----	119
Table P—Unit costs for disability claims initially adjudicated by State agencies for fiscal years 1958-61-----	119
Table Q—Selected data on State agency operations for fiscal year 1959--	120-122
Table R—Average processing time in calendar days for disability cases by type of determination: Selected months-----	123
Table S—Average State agency processing time of disability cases, initial determinations, June 1959: All cases, cases requiring development, and cases not requiring development-----	124-125
Table T—Number and percent of State jurisdictions by average processing time, June 1959: Cases requiring development and cases not requiring development-----	126
Table U—OASI vocational rehabilitation referral program: Number of disability applicant cases closed from State rehabilitation rolls to date and number and percent successfully rehabilitated by age and type of application-----	129
Table V—OASI vocational rehabilitation referral program: Number of disability freeze and benefit applicants closed from State rehabilitation agency rolls to date and number and percent rehabilitated by age and year of onset of disability-----	130-131
Table W—OASI vocational rehabilitation program: Number of disability applicant cases closed from State rehabilitation agency rolls to date and number and percent successfully rehabilitated by State and type of application-----	132-133
Table X—OASI vocational rehabilitation referral program: Number of disability freeze and benefit cases closed from State rehabilitation agency rolls to date and number and percent successfully rehabilitated by State and age-----	134-136
Table Y—OASI vocational rehabilitation referral program: Disability freeze and benefit applicants considered for rehabilitation services and number and percent accepted for services by age and sex, 1958-----	139
Table Z—OASI vocational rehabilitation referral program: Childhood disability applicants considered for rehabilitation services and number and percent accepted for services by age and sex, 1958-----	140
Table AA—OASI vocational rehabilitation referral program: Disability freeze and benefit applicants considered for rehabilitation services and number and percent accepted for services by age and year of onset of disability, 1958-----	141-142

CONTENTS

IX

Table AB—OASI vocational rehabilitation referral program: Disability applicants considered for rehabilitation services and number and percent accepted for services by State and type of application, 1958.....	Page 143-144
Table AC—OASI vocational rehabilitation referral program: Disability freeze and benefit applicants considered for rehabilitation services and number and percent accepted for services by State and age, 1958.....	145-147
Table AD—Monthly data.....	153-155
Table AE—Fiscal year data.....	156-157
Table AF—Comparative data.....	158
Table AG—Worker disability allowances: Number and percentage distribution of workers for whom a period of disability was allowed in 1957, by age and sex.....	159
Table AH—Worker disability allowances: Number and percentage distribution of workers for whom a period of disability was allowed in 1957, by age and sex, and by year of onset of disability.....	160-161
Table AI—Worker disability allowances: Number and percentage distribution of workers for whom a period of disability was allowed in 1957 by age and mobility status.....	161
Table AJ—Worker disability allowances: Number of workers for whom a period of disability was allowed in 1957, by sex, and percentage distribution by diagnostic group and primary diagnosis.....	162-165
Table AK—Worker disability allowances: 10 primary diagnoses occurring most often among workers for whom a period of disability was allowed in 1957, by sex, and percent of total.....	166-167
Table AL—Worker disability allowances: 10 primary diagnoses occurring most often among workers for whom a period of disability was allowed in 1957, by age, and percent of total.....	168-169
Table AM—Worker disability allowances: Number and percentage distribution of workers for whom a period of disability was allowed in 1957 by diagnostic group and by age and sex.....	170-172
Table AN—Worker disability allowances: Number of workers for whom a period of disability was allowed in 1957, by diagnostic group and age, and percentage distribution by year of onset of disability.....	173-174
Table AO—Worker disability allowances: Number and percentage distribution of workers for whom a period of disability was allowed in 1957, by age, sex, marital status, and number of children under age 18....	175-177
Table AP—Worker disability denials: Number and percentage distribution of workers for whom a period of disability was denied in 1957, by age and sex, and by reason for denial.....	178-180
Table AQ—Worker disability denials: Number and percentage distribution of workers for whom a period of disability was denied in 1957, by diagnostic group and by age and sex.....	181-183
Table AR—Childhood disability allowances: Number of children found disabled in 1957, by sex, and percentage distribution by diagnostic group and primary diagnosis.....	184-185
Table AS—Childhood disability allowances: 10 primary diagnoses occurring most often among children who were found disabled in 1957, by sex, and percent of total.....	186-187
Table AT—Childhood disability denials: Number and percentage distribution of children found not disabled in 1957, by age and sex and by reason for denial.....	188-189
Table AU—Continuing disability determinations: Number of determinations made after field investigation, and number and percent of disability cessations by age and sex, 1958.....	193
Table AV—Continuing disability determinations: Number of determinations made after field investigation by cessation or continuance and age, and percentage distribution by reason for continuance or cessation, 1958..	194-195
Table AW—Continuing disability determinations: Number and percent of determinations made after field investigation by continuance and cessation and by diagnostic group and selected primary diagnoses, 1958..	196-197
Table AX—Continuing disability determinations: Number of determinations made after field investigation and number and percent of cessations by diagnostic group, selected primary diagnoses, and age, 1958.....	198-199
Table AY—Continuing disability determinations: Number and percent of determinations made after field investigation by continuance or cessation, year of onset of disability and age, 1958.....	200-201

Table AZ—Continuing disability determinations: Number and percent of determinations made after field investigation by continuance and cessation and by estimated rate of annual earnings, 1958.....	Page 202
Table BA—Continuing disability determinations: Number of determinations of continuance made after field investigation by nature of work activity, estimated rate of annual earnings, and percentage distribution by reason for continuance, 1958.....	203
Table BB—Continuing disability determinations: Number and percent of determinations made after field investigation by continuance and cessation and by occupational group and nature of employer during period investigated, 1958.....	204–205
Table BC—Total number of disability cases processed by Bureau, number and percent for which consultative medical examinations purchased, and total costs, by quarter, fiscal years 1956–59.....	206
Table BD—Number of consultative examinations purchased during fiscal year 1959 by quarter and percent of total disability cases processed by Bureau: Initial determinations, and reconsideration and hearing requests.....	207

DISABILITY INSURANCE FACT BOOK

PART I

BRIEF SUMMARY OF THE DISABILITY PROGRAM

SCOPE OF THE LEGISLATION

The Congress enacted the first operative disability provision in title II of the Social Security Act just 5 years ago in 1954. These amendments established the so-called disability "freeze" program which is analogous to the "waiver of premium" provision commonly used in private life insurance to continue protection to the disabled individual without premium payments and without regard to ability to make such payments.

In 1956, the Congress added a program of cash benefits for disabled workers age 50 or over and authorized the payment of social security benefits to disabled children 18 and over with a present disability which began before age 18. The basic framework of standards and administrative procedures which had been developed for the "freeze" was made applicable to the cash benefits program. Last year (1958) the Congress authorized benefits for the dependents of disabled workers in the same manner as provided for the dependents of retired workers.

As of the end of May 1959, slightly over one-half million individuals were receiving payments or increased payments as a result of the disability program. In addition, about 100,000 workers had "frozen" records under the program. The payment beneficiaries were: about 269,000 disability insurance beneficiaries; about 78,000 dependents of disability insurance beneficiaries; 61,000 childhood disability beneficiaries; and about 95,000 old-age and survivors insurance beneficiaries under the general program in receipt of higher payments by virtue of a previous "freeze" of a worker's record.

(For a fuller history of the origins and development of the legislation see Part II. A summary of the statutory provisions appears in Part IX and a summary of operating statistics and experience in Part IV.)

ELIGIBILITY REQUIREMENTS

The Committee on Ways and Means stated in the report on the 1956 legislation that it had "designed a conservative program of disability insurance benefits." Under present law, eligibility for disability insurance benefits is limited to "fully insured" individuals aged 50 or over who have social security coverage for 5 out of the last 10 years prior to their disability; a waiting period of 6 months after the onset of the disability is required before payments commence; and, finally, the person applying has to meet the definition of disability

which is specified in the law. (For a full explanation of the eligibility requirements for insurance benefits and for an explanation of the requirements for the "freeze" and disabled children's benefits see the summary of law in Part IX.)

THE DEFINITION

The definition can be described in a general sense as one requiring permanent and total disability. This expression, however, is not in the law, the precise wording being that the individual must be unable—

to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration.

For the "freeze," but not for benefits, a specified degree of blindness is presumed to be disabling.

The Department of Health, Education, and Welfare has emphasized that the law requires the application of the definition on an individual basis. In the 1956 Senate Finance Committee hearings a statement submitted by the Commissioner of Social Security says that the—

policy, in line with the precedents set by the courts and in line with the experience of other disability programs, is that each case must be considered on all its facts.

The definition itself is quite similar to the "unable to engage in any regular employment" requirement of the "nonoccupational" definition in the Railroad Retirement Act, and to the requirement in the regulations under the U.S. Government life insurance program (World War I) administered by the Veterans' Administration of—

any impairment of mind or body which continuously renders it impossible for the disabled person to follow any substantially gainful occupation and which is founded upon conditions which render it reasonably certain that the total disability will continue throughout the life of the disabled person.

Other Federal disability program definitions differ in varying degrees. The social security concept of disability determination on an "individual" basis is distinguishable from the Veterans' Administration rating schedule under which impairments are judged by their effect on the "average" man for pension and compensation purposes. On the other hand, the national service life insurance program (World War II) has a definition similar to the U.S. Government insurance and social security programs but there is no requirement of permanent disability other than that the individual must have been disabled for 6 months. The social security definition differs substantially, however, from the occupational disability concept in the Civil Service Retirement Act and in the Railroad Retirement Act. (For a summary of selected Federal disability programs and definitions see Part XI.)

Most of the discussion in regard to the administration of the social security disability program has centered around the application of the definition of disability. Thirty-eight percent of the applicants whose claims required a determination of disability (some claims do not because of failure to meet insured status requirements, for example) were denied on the ground that the individual's impairment was not severe enough to meet the definition specified in the act. (See Parts IV and X for statistics on denials under the program.)

Certain aspects of the definition are worthy of special emphasis.

(1) *Inability to engage in substantial gainful activity*

The departmental regulations which spell out the definition in more detail emphasize that, in determining whether an individual is unable to engage in such activity, primary consideration is given to the severity of his impairment. Consideration is also given to such other factors as the individual's education, training, and work experience. Although the regulations state that each case will be determined on its own particular facts, certain specified impairments would ordinarily be considered as preventing substantial gainful activity in the absence of work or other evidence to the contrary.

The Department has developed quite detailed medical standards for the use of the State and Federal personnel who evaluate disability. The Department emphasizes, however, that this listing should not be considered as a formal medical rating schedule. The question in every case is whether the individual's impairment renders him unable to engage in any substantial gainful activity, considering his age, education, and work experience.

The fact that an individual works raises the issue as to whether he has the capacity to engage in substantial gainful activity. Generally, the Department holds that the amount of earnings is the most significant factor in this determination. The nature of the activity, the time on the job, and the duration of work may be taken into account under certain circumstances.

(2) *By reason of any medically determinable physical or mental impairment*

An individual must not only be unable to engage in any substantial gainful activity but the reason for this inability must be his medically determinable impairment. The Department states that—

a person may become unemployed or remain unemployed for a number of reasons other than disability: individual employer hiring practices, technological changes in the industry in which the applicant has been employed, local or cyclical business or economic conditions, and many others (OASI-29f).

It is emphasized that the disability provisions are intended to benefit only those who lack capacity and not those who are unemployed because of other factors. The Department requires that the impairment must be the primary reason for the individual's inability to engage in substantial gainful activity.

(3) *Permanency of impairment*

The definition requires that the physical or mental impairment must be one that can be expected to be of long-continued and indefinite duration or that can be expected to result in death. The regulations state that "indefinite" is used in the sense that it cannot reasonably be anticipated that the impairment will, in the foreseeable future, be so diminished as no longer to prevent substantial gainful activity. The impairment does not have to be everlasting. The Department has stated that although there is a possibility that, through new discoveries in medical science or rehabilitation techniques, the individual may engage in substantial gainful activity in the future, such a possibility does not mean that the individual's impairment should not qualify under the definition.

(4) *Remediable conditions*

A condition which is remediable to the extent that it would not prevent the individual from engaging in substantial gainful activity is, according to departmental regulations, a bar to benefits. Exceptions to this would be where the therapy needed was not generally accepted or where the individual could not accomplish the treatment with reasonable effort and safety to himself.

(For a full discussion of standards used in determining disability under the act see Part III. For court cases regarding the interpretation of disability see Part VI.)

METHOD OF DETERMINING DISABILITY

Determinations of disability are made by the State agency using the standards prepared by the Department. The Department itself makes the determination for persons outside the country and for some persons inside the country where a State under its agreement has specified certain cases not to be processed by it. Usually the State vocational rehabilitation agency makes the determination using an evaluation team consisting of a physician and a specialist both trained in disability evaluation. (See pp. 107-110 for State agency denial rates and pp. 124-126 for State agency processing time.)

The State agencies have progressively undertaken a higher proportion of the cases requiring an application of the definition of disability. From the beginning of the program to the end of May 1959 over 1.1 million of these determinations had been made: 412,600 (36 percent) by the Bureau of Old-Age and Survivors Insurance and 725,200 (64 percent) by the State agencies.

(See Part V for a full explanation of the disability claims process and Part IV for statistics and a summary of disability operating experience.)

REVIEW OF DETERMINATIONS

All determinations are reviewed by the Bureau for consistency with its standards. Denials of disability cannot be reversed by the Bureau under the law, but it is the practice to send questioned cases back to the State agency. It should be emphasized that the State agency in such a situation is under no obligation to change the initial determination, and sometimes will not do so. (See pp. 110-116 for statistics on questioned cases returned to the States.)

The Bureau does have the right, however, to change a State agency determination that an individual is disabled or change the date of the onset of the disability to a more recent date.

RIGHT OF ADMINISTRATIVE APPEAL

A person who is dissatisfied with the decision in his case can ask (1) to have his case reconsidered under procedures established by regulation, and, if still dissatisfied, (2) to be heard as a matter of statutory right by a referee of the Social Security Appeals Council. The referee can, under the law, reverse the finding of either the State agency or the Bureau. If the decision is against the claimant he may request the Appeals Council to review the case and the Council may do so at its discretion. As a matter of procedure, the Council will generally decline formal review if examination of the case shows that

formal review would not be of any advantage to the appellant. The Council is empowered to reverse the referee on the appeal of the applicant or on its own motion. Certain time limits are fixed for each of the various appeals steps.

The impact of the disability provisions on the social security appeals procedures has been very great. In 1958, 50 percent of the approximately 92,000 total reconsideration requests involved the determination of disability. Similarly, over 70 percent of the 23,000 total hearing requests were on the issue of disability. Eight times as many social security reconsideration cases and four times as many hearing cases were processed in 1958 as in 1955.

(For workload implications of reconsiderations, hearings, and appeals to the Council, and for increase in referees in relation to workload see Part VI. See p. 123 for processing time for reconsideration and hearings.)

The reversal rate for reconsidered disability cases was about 29 percent in 1958 and 36 percent for the first 3 months of 1959. As to hearings on disability, in 1958 referees sustained the Bureau in 75 percent of the cases, reversed it in 4 percent, and remanded in 17 percent for favorable action at the request of the Bureau. Comparable figures for the first 3 months of 1959 show about 70 percent sustained, 8.4 percent reversed, and 12.9 percent remanded for favorable action for the claimant. (Cases not accounted for include such actions as dismissals for lack of timely hearing request, lack of jurisdiction, etc.)

(See Part VI for a more detailed breakdown.)

APPEAL TO THE COURTS

After the final administrative remedy has been properly exhausted (namely, the Appeals Council has acted, either by review and decision on the merits, or by declining to review thereby allowing the referee's decision to stand as the final administrative action) the individual may bring an action to review the determination in the U.S. district court in the judicial district in which he lives. An opportunity is always available to present new evidence at the referee stage; the Council on review may or may not offer this opportunity, depending upon the nature of the case. The Federal courts will only review the case on the record to ascertain whether the law was properly applied, and whether there is substantial evidence in the record to support the findings. The court may, of course, remand the case for the taking of further evidence.

The number of court cases under the disability provisions is sharply rising as more final administrative decisions are handed down. Forty disability cases were brought in 1957; 120 in 1958; and 61 in the first 3 months of 1959. As with administrative appeals, and for similar reasons, disability cases represent an increasing proportion of all court cases brought under the social security program: 59 percent in 1958 and 79 percent in the first quarter of 1959. Of the 31 disability decisions handed down by district courts from January 1, 1958, through March 31, 1959, 17 affirmed the Department's decision, 6 reversed in whole or in part, and 8 dismissed because of action favorable to the plaintiff on remand. As of March 31, 1959, there were 189 disability cases pending which constituted 60 percent of all the pending cases on the social security program.

(See Part VI for more detailed breakdown of court cases and for summaries of individual cases.)

REHABILITATION

Rehabilitation has been stressed by the Congress in passing both the "freeze" and benefits provisions. The law states:

It is hereby declared to be the policy of the Congress that disabled individuals applying for a determination of disability, and disabled individuals who are entitled to child's insurance benefits, shall be promptly referred to the State agency or agencies administering or supervising the administration of the State plan approved under the Vocational Rehabilitation Act for necessary vocational rehabilitation services, to the end that the maximum number of such individuals may be rehabilitated into productive activity.

Under arrangements between the Office of Vocational Rehabilitation and the Social Security Administration, those applicants for determination of disability who show some potential for rehabilitation are identified by the evaluation team of the State agency. The cases are forwarded to a rehabilitation counselor who conducts a further study to see if such individuals meet the requirements for services under the Vocational Rehabilitation Act.

From 1955 through the end of June 1959, more than 1,310,000 persons had been referred to State vocational rehabilitation agencies for consideration. This figure includes 1,052,401 disability applicants and 257,721 individuals who made inquiry of a Bureau district office but did not file applications. About 140,900 disability applicants have been selected for further vocational rehabilitation consideration. No information is presently available as to how many of these have actually been accepted for rehabilitation services. (See pp. 137-147 for figures on acceptances in 1958.)

During fiscal years 1957 and 1958, about 2,200 disability referrals (applicants and nonapplicants) have been reported as rehabilitated. Information is not available as to what proportion of these rehabilitated individuals were those who had been allowed disability benefits. There is some Bureau data which suggests that the proportion may be around 25 percent.

The Bureau states that through April 1959, 2,647 applicants for disabled worker benefits had been reported by the State agencies as rehabilitated. (See pp. 126-136 for detailed breakdown of statistics on disability applicants rehabilitated by State vocational rehabilitation agencies.)

Provision is also made in the law for deductions of benefits where the disabled individual refuses, without good cause, to accept rehabilitation services under an approved State plan. Moreover, in order to avoid setting up barriers to vocational rehabilitation, the law provides that benefits may be continued for individuals who undergo rehabilitation services, pursuant to an approved State plan, extending through the period of rehabilitation, but not to exceed 12 months after placement in gainful employment.

COST OF THE PROGRAM

Congress has always insisted that the social security program be on an actuarially sound basis and the contribution rate in the law is designed to support the system into the indefinite future.

In 1956 the Congress earmarked an amount equal to one-half of 1 percent of taxable payroll of covered employees (plus three-eighths of 1 percent of covered earnings of self-employed) to go into a separate trust fund for the disability insurance program. At that time, Robert J. Myers, the Chief Actuary of the Social Security Administration, estimated that the long-term intermediate costs of the program would be 0.42 percent of covered payroll. By 1958, however, Mr. Myers had revised this estimate downward to 0.35 percent of covered payroll. Congress in 1958 made certain changes in the disability program—adding dependents' benefits, increasing the level of benefits and the maximum taxable and creditable earnings base, modifying the insured status requirement, and eliminating the offset of certain other disability payments—so as to all but eliminate the estimated actuarial "surplus" and bring the cost of the disability program to 0.49 percent of payroll on a long-term intermediate basis. As to the actual cost experience thus far under the program, Mr. Myers states:

The actual experience to date under the very strict definition of "disability" in the law has been significantly lower in cost than the intermediate-cost assumptions would indicate. Nevertheless, until somewhat more experience is available and can be analyzed, it is believed that these cost bases for the monthly disability benefits should be maintained. Disability incidence and termination rates can vary widely—much more so than mortality rates, which are a basic factor in the retirement and survivor benefit cost calculations ("Actuarial Cost Estimates and Summary of Provisions of the Old-Age, Survivors, and Disability Insurance System as Modified by the Social Security Amendments of 1958," Ways and Means Committee print, September 2, 1958, p. 6).

(For a discussion of the basic assumptions for the cost estimates and an analysis of current experience see Part VIII.)

PART II

THE DEVELOPMENT OF THE DISABILITY PROGRAM UNDER OLD-AGE AND SURVIVORS INSURANCE, 1935-58

CONSIDERATIONS OF DISABILITY INSURANCE, 1935-39

(a) *The 1935 Report to the President of the Committee on Economic Security*¹

This report recognized the problems of earnings lost during periods of disability, but specific consideration was not given to the problems of permanent and total disability.

(b) *The Final 1938 Report of the Advisory Council on Social Security to the Senate Committee on Finance*²

The Council recognized the desirability of providing benefits to an insured person who becomes totally and permanently disabled and to his dependents. However, a difference existed in the Council on the timing of the introduction of these benefits. Those in favor of immediate introduction argued that permanently disabled persons (except the blind) were the only category of permanent social casualties who receive no insurance or assistance under the Social Security Act, and that no other group was more completely dependent or in a more desperate economic situation. Those Council members in favor of further study before establishing disability benefits argued that costs were unpredictable and that the initiation of the new benefits should wait until probable total program costs could be more accurately projected. They also envisioned many difficult administrative problems of a character apart from the rest of the program, such as the necessity for a skilled staff to make disability determinations in each case and for intensive and sustained local investigation to prevent abuses.

(c) *The 1938 Annual Report of the Social Security Board to the President*³

In recommending changes in the Social Security Act, the Board gave considerable thought to whether the system should be expanded to include provisions for benefits to workers who become permanently and totally disabled, before reaching age 65, and to their dependents. Recognizing the difficult, but not insuperable administrative problems and the increased cost of the provision, the Board made no positive recommendation. The Board did state that the extent of the increase in costs would depend upon the definition of disability, and that a strict definition at the beginning would keep costs within reasonable limits. Later, with experience, the definition could be made more liberal if this was considered socially desirable. It was suggested that

¹ See hearings before the Committee on Ways and Means, 74th Cong., 1st sess. (1935), on H.R. 4120, p. 17 et seq.

² See hearings relative to the Social Security Act Amendments of 1939 before the Committee on Ways and Means, vol. 1, p. 18 et seq.

³ Ibid., p. 3 et seq.

any plan for permanent total disability insurance should have adequate provisions for hospitalization and other institutional care, and vocational rehabilitation.

- (d) *The 1939 Report to the President on National Health by the Interdepartmental Committee to Coordinate Health and Welfare Activities*⁴

After a survey of the problems of disabled persons, the Committee concluded that wage earners and their families need protection against loss of income during periods of temporary or permanent disability. The Committee recommended the development of social insurance to replace in part wages lost during temporary or permanent disability. It suggested that insurance against permanent disability should be effected through a liberalization of the old-age insurance system, paying benefits at any time prior to age 65 to qualified workers who become permanently and totally disabled.

- (e) *Social Security Act Amendments of 1939*

There were no provisions on disability in the 1939 amendments to the Social Security Act; nor was any mention made of disability in the Committee reports accompanying the bill which later was enacted by the Congress.

CONSIDERATIONS OF DISABILITY INSURANCE, 1940-50

- (a) *Annual reports of the Social Security Board from 1940 to 1950*

Throughout this period, the Social Security Board (and its successor, the Social Security Administration) recommended in its annual reports the payment of social insurance benefits to permanently and totally disabled persons. Some of the specific proposals made to implement this recommendation were as follows:

- (1) Benefits should be payable only after a 6-month waiting period and then only if the disabled person had been in covered employment within a reasonably recent period, for a reasonably substantial time, and with reasonably substantial income.
- (2) Benefits should be paid to dependents of disabled workers.
- (3) Vocational rehabilitation for beneficiaries should be financed from the trust fund.

As for the definition of disability, the Board stated that for "permanent" disability to imply a concept of lifetime disability, requiring a medical prognosis of permanency, was socially and administratively unsatisfactory. Instead, benefits should be paid for loss of earnings after a suitable waiting period (6 months) and for the duration of total incapacity for substantially gainful work.

- (b) *The 1946 Report to the Committee on Ways and Means by the Committee's social security technical staff*⁵

After an analysis of the problems involved in long-term disability benefits provided as an extension of OASI, this report—known as the Calhoun report—suggested as an initial step that such benefits be provided only to persons above some specified age, such as 55 or 60. It was felt that this would be a promising method for easing into

⁴ H. Doc. No. 120, 76th Cong., 1st sess. (1939).

⁵ Issues in social security: A report to the Committee on Ways and Means of the House of Representatives by the committee's social security technical staff established pursuant to H. Res. 204 (79th Cong., 1st sess.), 1946.

disability insurance with a minimum of initial difficulty, although it was recognized that it would not touch the areas where the consequences of disability were the most serious.⁶

(c) *Social Security Act Amendments of 1946*

These amendments were limited in scope and dealt only with simple and noncontroversial legislative changes; they did not include a provision for disability insurance.

(d) *The 1948 Report of the Advisory Council on Social Security to the Senate Committee on Finance*⁷

The Council recommended payment of benefits to the permanently and totally disabled, regardless of age, as part of the social insurance system. (Two members of the Council disagreed with this recommendation. They felt that protection against the risk of total disability should be provided by State assistance programs aided by Federal grants and should not be included in a Federal contributory system.) Some of the specific recommendations of the Council were—

(1) A strict test of recent and substantial attachment to the labor market should be a condition of eligibility. The individual would need a minimum of 40 quarters of coverage, at least 1 quarter of coverage for every 2 calendar quarters in his working lifetime before the onset of disability, at least 6 quarters of coverage in the 12 quarters preceding such onset, and at least 2 quarters of coverage in the 4 quarters preceding such onset.

(2) The definition of disability would mean "any disability which is medically demonstrable by objective tests, which prevents the worker from performing any substantially gainful activity, and which is likely to be of long-continued and indefinite duration."⁸

(3) Qualified individuals would be eligible for benefits after a waiting period of 6 months. Such a waiting period was recommended "because it is sufficiently long to permit most essentially temporary conditions to clear up or show definite signs of probable recovery."⁹

(4) No benefits would be provided for dependents.

(5) Benefits would be suspended where workmen's compensation was payable; if another Federal program paid a disability benefit, only the larger benefit would be paid. It was felt that dual benefits based on disability would be so high as to discourage beneficiaries from returning to gainful work when they are able to do so.¹⁰

(6) The provisions for disability benefits and for old-age and survivors benefits would be so integrated that periods of total disability would not be counted in computing insured status and the average monthly wage of a disabled person.

(7) Rehabilitation services would be provided and paid from the trust fund.

⁶ Ibid., p. 101. In its 1947 report, the Social Security Administration argued against the suggestion that benefits be limited to disabled workers over age 55 by emphasizing that the consequences of disability may be more disastrous for the younger than the older worker. See annual report of the Federal Security Agency (1947), pp. 62 and 63.

⁷ S. Doc. No. 162, 80th Cong., 1st sess. (1948).

⁸ Ibid., p. 5.

⁹ Ibid., p. 7.

¹⁰ Ibid., p. 9.

SOCIAL SECURITY ACT AMENDMENTS OF 1950

Many of the details of the present disability program had their origin in the bill, H.R. 6000, which eventually became the 1950 amendments to the Social Security Act. This bill, as passed by the House of Representatives late in 1949, contained provisions for the payment of disability insurance benefits under title II of the Social Security Act to permanently and totally disabled insured workers. In support of its action recommending such a program to the House of Representatives, the Committee on Ways and Means relied upon the recommendations of the 1948 Advisory Council. In the view of the committee, the program it recommended was conservative inasmuch as it:

would only apply to those wage earners and self-employed persons who have been regular and recent members of the labor force and who can no longer continue gainful work.¹¹

The Senate, however, deleted the disability insurance provisions when it passed H.R. 6000. In its report on H.R. 6000, the Senate Committee on Finance expressed the following views on the disability insurance program:

Your committee has not included permanent and total disability insurance or assistance provisions in the bill. We recognize that the problem of disabled workers is one which requires careful attention, especially because of the increasing proportion of older workers and the rising rate of chronic invalidity in the population. Moreover, the problem is not limited to the feasibility of providing income or pensions merely to maintain disabled workers. At least of equal significance is the need for assuring fullest use of rehabilitation facilities so that disabled persons may be returned to gainful work, whenever this is possible. Your committee believes that the Federal Government should increase the grants-in-aid to the States for vocational rehabilitation and that further study should be made of the problem of income maintenance for permanently and totally disabled persons.¹²

The conference committee went along with the Senate version of the bill as to disability insurance benefits, and as finally passed by the Congress the bill made no provision for disability insurance benefits. The legislation did, however, extend the State-Federal public assistance programs to the permanently and totally disabled by providing grants-in-aid to the States for such individuals who are in need, as had been recommended by the minority of the 1948 Advisory Council.¹³

Some of the salient features of the disability insurance program passed by the House of Representatives as part of H.R. 6000 were—

(1) To be insured, the individual needed 20 quarters of coverage in the 40-quarter period ending with the quarter of disablement (the same as present law) and 6 quarters of coverage in the 13-quarter period ending with such quarter.

(2) The definition of disability was the same as the present definition for the payment of disability insurance benefits, except that the disability had to be “medically demonstrable” and “permanent,” and blindness (defined as it now is for purposes of the disability “freeze”) was included within the definition.¹⁴ Benefits were to be paid only after a waiting period of 6 months

¹¹ H. Rept. No. 1300, 81st Cong., 1st sess. (1949), pp. 27 and 28.

¹² S. Rept. No. 1669, 81st Cong., 2d sess. (1950), p. 3.

¹³ Title XIV, Social Security Act.

¹⁴ See pp. 99 and 100 of pt. IX of this “Fact Book.”

(as under present law). In this regard, the Committee on Ways and Means made it clear that the 6-month period was not a basis for a presumption of permanence or protracted total disability. Where recovery could be expected, according to medical prognosis, within relatively short periods of time after the expiration of the 6-month waiting period, such cases would not be compensable under the definition of disability. The committee felt that a cautious approach to the payment of benefits was necessary to prevent abuses.¹⁵

(3) There was no age limitation such as the requirement in present law that an individual must be at least age 50 to receive benefits; nor was provision made for the payment of benefits to dependents.

(4) An individual's insured status and benefit amount for purposes of old-age and survivors insurance were preserved (i.e., a disability "freeze" was established) while he was entitled to disability insurance benefits.

(5) Determinations of disability were to be made by the Administrator of the Federal Security Agency (predecessor of the Secretary of Health, Education, and Welfare).

(6) Benefits were to be adjusted in cases where the beneficiary was also receiving a workmen's compensation benefit for the same disability during the same period of time.

(7) Benefits were to be suspended where, among other things, an individual who was still disabled had earnings in excess of a permitted amount or where he failed, without good cause, to accept certain rehabilitation services or to undergo medical examinations.

SOCIAL SECURITY ACT AMENDMENTS OF 1952

The 1952 amendments to the Social Security Act provided for a disability "freeze" (not disability insurance benefits) with an effective date of July 1, 1953, but only if the Congress prior to that date affirmatively approved the provision. The Congress did not take any action prior to July 1, 1953. As a result, the disability "freeze" in the 1952 amendments never became operative.

The 1952 amendments had their origin in H.R. 7800, which was reported out by the Committee on Ways and Means of the House of Representatives with a provision for a disability "freeze" similar in many respects to the disability "freeze" in present law. The committee included in the bill a provision which authorized the Administrator of the Federal Security Agency to make determinations of disability—a like provision having appeared in H.R. 6000 as passed by the House of Representatives in 1949. This provision came under heavy attack on the floor of the House of Representatives¹⁶ and was eventually deleted from the bill. As finally passed by the House of Representatives, the bill contained no specific provision as to who would make determinations of disability.

¹⁵ H. Rept. No. 1300, 81st Cong., 1st sess. (1949), pp. 29 and 30.

¹⁶ Congressional Record, vol. 98, p. 5466 et seq. (May 19, 1952).

The Senate Committee on Finance recommended the passage of H.R. 7800 without any provision for a disability "freeze." In taking this action, the committee stated:

In deleting these provisions, your committee did not prejudge the merits of these proposals. There was insufficient time for full hearings which would have been necessary if proper consideration were given to these two provisions and the numerous amendments suggested thereto.¹⁷

The Senate followed the recommendations of the Committee on Finance.

In conference, it was agreed to recommend the inclusion of the disability "freeze" as passed by the House of Representatives with the following two notable changes—(1) determinations of disability would be made by States through appropriate agencies pursuant to agreements between the States and the Administrator; and (2) the provision would become operative only if Congress later affirmatively approved it.¹⁸

Although the disability "freeze" in the 1952 amendments never went into effect, its specific provisions later served as a basis for the disability "freeze" enacted in the 1954 amendments.

SOCIAL SECURITY AMENDMENTS OF 1954

These amendments established the first operating disability program under the Social Security Act. They provided a disability "freeze" for disabled workers and, except for a few amendments enacted since 1954, the provision is the same as present law.

The definition of "disability" was basically the same as the definition which appeared in H.R. 6000 as passed by the House of Representatives in 1949, and is still in the law.

The insured status requirements for a "freeze" were 20 quarters of coverage in the 40-quarter period ending with the quarter of disablement and 6 quarters of coverage in the 13-quarter period ending with such quarter—the same as appeared in H.R. 6000 as passed by the House of Representatives in 1949. (Under present law, the "20-out-of-40" requirement still exists, while the "6-out-of-13" requirement was repealed in 1958.)¹⁹

As under present law, the "freeze" was retroactive to the date of onset of disability, which could be as early as the fourth quarter of 1941. The law provided, however, that retroactivity could exceed no more than 12 months if the application was filed after June 30, 1957. (Under present law, retroactivity may cover no more than 18 months, if the application is filed after June 30, 1961. However, applications filed before July 1, 1961, are fully retroactive with respect to the starting date of a period of disability.)²⁰

In addition, Congress, recognizing the importance of rehabilitating disabled persons, specifically provided for the referral of such persons to State rehabilitation agencies for rehabilitation services:

to the end that the maximum number of disabled individuals may be restored to productive activity.²¹

¹⁷ S. Rept. No. 1806, 82d Cong., 2d sess. (1952), p. 2.

¹⁸ The purpose of this, according to the conference committee, was to "permit appropriate steps to be taken for the working out of tentative agreements with the States for possible administration of [the disability] provisions" and to allow further hearings to be held. H. Rept. 2491, 82d Cong., 2d sess. (1952), p. 9.

¹⁹ See p. 17 *infra*.

²⁰ See p. 17 *infra*.

²¹ See p. 103 of pt. IX of this "Fact Book."

In all other respects (State determinations and effect of freeze) the law enacted in 1954 is the same as present law.²²

In moving from determinations of disability made by the Federal Government (as provided in H.R. 6000 passed by the House of Representatives in 1949) to State determinations (as first promulgated in the inoperative 1952 provision), the Committee on Ways and Means stated:

By and large, determinations of disability will be made by State agencies administering plans approved under the Vocational Rehabilitation Act. This would serve the dual purpose of encouraging rehabilitation contacts by disabled persons and would offer the advantages of the medical and vocational care development undertaken routinely by the rehabilitation agencies. These agencies have well-established relationships with the medical profession and would remove the major load of case development from the Department.

By agreement, the State agencies will apply the standards developed for evaluating severity of impairments for purposes of the freeze. This will promote equal treatment of all disabled individuals under the old-age and survivors insurance system in all States. The cost to these agencies for their services in making disability determinations will be met out of the Trust Fund.²³

SOCIAL SECURITY AMENDMENTS OF 1956

Monthly disability insurance benefits were provided under the 1956 amendments to eligible disabled workers between the ages of 50 and 65. In addition, benefits were provided for disabled dependent children of a retired or deceased insured worker if the child was disabled before he attained the age of 18.

These changes in the Social Security Act were first included by the Committee on Ways and Means in H.R. 7225, the bill which later became the 1956 amendments to the Social Security Act. The provisions relating to the disabled insured workers were patterned after the provisions on disability appearing in H.R. 6000 as passed by the House of Representatives in 1949, except that benefits were to be paid only to individuals between the ages of 50 and 65. The provisions in the bill relating to childhood disability benefits were somewhat restrictive in that they applied only if the child was on the benefit rolls prior to attainment of age 18. H.R. 7225 was passed by the House of Representatives in 1955.

The Senate Committee on Finance, which held hearings on the bill in 1956, recognized the problems of the severely disabled worker but did not agree that disability insurance benefits should be provided under the old-age and survivors insurance system. This was the position taken by Secretary of Health, Education, and Welfare Folsom, in testifying before the committee. The committee, in opposing a cash disability insurance benefit program, considered: (1) The difficulty in making disability determinations, (2) the availability of assistance under the program of aid to the permanently and totally disabled, (3) the significant strides made in vocational rehabilitation, (4) the uncertainty as to the future costs of a cash disability insurance benefit program, and (5) the need for time to study and evaluate existing disability programs.²⁴

It did, however, recommend the adoption of the provisions relating to the payment of childhood disability benefits, except that it removed

²² See pp. 101, and 102 of pt. IX of this "Fact Book."

²³ H. Rept. 1698, 83d Cong., 2d sess. (1954), pp. 23 and 24.

²⁴ S. Rept. 2133, 84th Cong., 2d sess. (1956), pp. 3 and 4.

the restriction that the child must be on the benefit rolls prior to attainment of 18; it sufficed that the child became disabled before 18. So long as that occurred, the childhood disability benefit would be paid to the child whenever the insured worker died or became entitled to old-age insurance benefits. The committee did not believe that the serious difficulties involved in paying benefits to disabled workers applied to children disabled before age 18, since most of the cases involving children would be the result of congenital conditions or conditions existing since early childhood, including mental deficiency.²⁵

When H.R. 7225 was acted upon by the Senate, an amendment providing for disability insurance benefits was adopted on the floor by a 47 to 45 vote. The amendment followed very closely the provision adopted by the House of Representatives in the preceding year with one notable exception—a separate trust fund was set up for the purpose of paying disability insurance benefits. This fund is held separate from the trust fund from which other benefits are paid and is the only source from which disability insurance benefits can be paid. The rate of contributions to this fund is one-half of 1 percent on wages (an employer rate of one-fourth of 1 percent and an employee rate of one-fourth of 1 percent) and three-eighths of 1 percent on the earnings of the self-employed.

In conference it was agreed to adopt the Senate's version of the disability insurance program with its separate trust fund, including the more liberal provision for the payment of childhood disability benefits.

As passed in 1956, the following pertinent provisions appeared:

(1) As under present law, benefits were payable if the individual was insured, was between the ages of 50 and 65, was under a disability, and had applied for benefits.²⁶ Benefits were payable beginning July 1957, and, except in the case of applications filed before January 1958, there was no retroactivity of benefit payments.

(2) Insured status provision: The same as present law,²⁷ except that it contained a requirement that the individual must be a currently insured individual (a requirement similar to the one then existing under the "freeze" of 6 quarters of coverage in the 13 quarters ending with the quarter of disablement).

(3) Definition of disability: The same as present law²⁸ and the same as the definition under the freeze, except that "blindness" is not presumed to be a disability for disability insurance benefits. A blind person has to meet the same definition as any other individual with a disabling condition, i.e., he must be unable to engage in any substantial gainful activity.

(4) As under present law, there must have been 6 months of disability before benefits could be paid.

(5) Disability insurance benefits were reduced in any case where the individual was receiving another Federal disability benefit or a State workmen's compensation payment.

(6) In addition to the provision on rehabilitation enacted as part of the 1954 amendments, further provisions on rehabilitation

²⁵ *Ibid.*, p. 2.

²⁶ See p. 99 of pt. IX of this "Fact Book."

²⁷ See p. 99 of pt. IX of this "Fact Book."

²⁸ See p. 99 of pt. IX of this "Fact Book."

were added, those dealing with the withholding of benefits for refusing rehabilitation services and the rendering of services under a State plan for vocational rehabilitation.²⁹

(7) The provisions relating to the definition of disability, rehabilitation, and reduction as applied to disabled insured workers were also applicable to childhood disability benefits.

(8) Determinations of disability were to be made by the States under the same conditions as determinations of disability were made under the freeze.

AMENDMENTS TO THE SOCIAL SECURITY ACT IN 1957 (PUBLIC LAW 85-109)

These amendments (Public Law 85-109) made the following changes:

(1) The 12-month limitation on retroactivity of the disability "freeze" did not apply if the application were filed prior to July 1, 1957. The 1957 amendments extended this date to July 1, 1958. The Committee on Ways and Means indicated concern:

that many persons who became disabled some time ago will, if they fail to file applications before July 1, 1957, lose all their protection under the old-age and survivors insurance program * * * it is only fair to give workers now disabled a further opportunity to avoid loss of these valuable rights * * *.³⁰

(2) Disability insurance benefits were reduced where the beneficiary was receiving a disability benefit under another Federal program. The 1957 amendments exempted from this provision veterans' compensation received on account of service-connected disabilities. According to the Committee on Ways and Means—

the purpose of veterans' compensation is such as to justify disregard of that compensation in the determination of rights to disability insurance benefits under the social security program.³¹

SOCIAL SECURITY AMENDMENTS OF 1958

The 1958 amendments broadened the protection of the disability program and removed certain provisions which had proved unnecessary and, in some situations, had caused inequities. The following modifications were made:

(1) Provision was made for the payment of monthly benefits to dependents of disability insurance beneficiaries.

(2) The amendments repealed the provision (known as the offset) which required the reduction of disability benefits where the beneficiary was receiving a workmen's compensation payment or a disability benefit from another Federal program. The Committee on Ways and Means expressed the view that "the danger that duplication of disability benefits might produce undesirable results is not of sufficient importance to justify reduction of social security disability benefits."³²

(3) Applications for disability benefits were made retroactive for as much as 12 months to prevent the loss of benefits where a beneficiary fails to file a timely application.³³ For a similar

²⁹ See p. 103 of pt. IX of this "Fact Book."

³⁰ H. Rept. 277, 85th Cong., 1st sess. (1957), p. 2.

³¹ Ibid., pp. 2 and 3.

³² H. Rept. 2288, 85th Cong., 2d sess. (1958), p. 13.

³³ Ibid., pp. 13 and 14.

reason, the deadline date for full retroactivity in the case of a disability "freeze" was extended from July 1, 1958, to July 1, 1961—applications for the freeze filed on or after July 1, 1961, will be retroactive for not more than 18 months.

(4) The insured status requirements for the disability "freeze" and disability insurance benefits were modified and made identical. The modification was the elimination of a recency-of-work test—i.e., the requirement of currently insured status for disability benefits and of "6 quarters of coverage out of 13 quarters" for the disability "freeze." The test was made identical by adding the requirement of a fully insured status for the "freeze." (In the 1956 amendments, "fully insured status" was included as a requirement for disability insurance benefits.)

The Committee on Ways and Means felt that the elimination of this recency-of-work test would be particularly helpful to persons with progressive illnesses. In many such cases, a person who is forced to stop working as a result of his impairment would lose his insured status before the impairment became sufficiently severe to meet the statutory definition of disability. The committee also felt that the fully insured status requirement was necessary for the disability "freeze" in order to avoid the anomalous situations that might arise after June 1961 with respect to workers who could qualify for a disability freeze and not be eligible for any disability or old-age benefits.³⁴

³⁴ Ibid., pp. 14 and 15.

PART III

THE DEVELOPMENT OF INTERPRETIVE MATERIALS FOR DETERMINING DISABILITY UNDER THE SOCIAL SECURITY ACT

THE LAW

The definition of the term "disability" for purposes of disability insurance benefits and the disability "freeze" of the Social Security Act is described in items 1(b), 2(b), 3(b) of Part IX of this Fact Book. The general legislative history of the definition and of other aspects of the disability program is contained in Part II of this Fact Book.

CONGRESSIONAL COMMITTEE REPORTS

In their reports on H.R. 9366, which became the 1954 amendments to the Social Security Act, the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate stated the following with respect to the definition of disability:

There are two aspects of disability evaluation: (1) There must be a medically determinable impairment of serious proportions which is expected to be of long-continued and indefinite duration or to result in death, and (2) there must be a present inability to engage in substantial gainful work by reason of such impairment (recognizing, of course, that efforts toward rehabilitation will not be considered to interrupt a period of disability until the restoration of the individual to gainful activity is an accomplished fact). The physical or mental impairment must be of a nature and degree of severity sufficient to justify its consideration as the cause of failure to obtain any substantial gainful work. Standards for evaluating the severity of disabling conditions will be worked out in consultation with the State agencies. They will reflect the requirement that the individual be disabled not only for his usual work but also for any type of substantial gainful activity.¹

At the time Congress provided for disability benefits, a further expression of intent as to the meaning of "disability" was included in the report of the Committee on Ways and Means on H.R. 7225 (the Social Security Amendments of 1956):

* * * Moreover, the definition of the term "disability" requires inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration. Thus, an individual who is able to engage in any substantial gainful activity will not be entitled to disability insurance benefits even though he is in fact severely disabled * * *.²

Although the Senate Committee on Finance in its consideration of H.R. 7225 recommended against the inclusion of disability insurance benefits in the OASI program, a minority on the committee disagreed and urged the Senate to include such benefits in the act. In light of the inclusion of disability insurance benefits in the bill which passed

¹ H. Rept. 1698, 83d Cong., 2d sess. (1954), p. 23; S. Rept. 1987, 83d Cong., 2d sess. (1954), p. 21.

² H. Rept. 1189, 84th Cong., 1st sess. (1956), p. 5.

the Senate, the statement on the definition of disability made by this minority is pertinent. It said:

The definition of disability contained in the proposal is a conservative one, limited to medically determinable physical or mental impairment which prevents the individual from engaging in any substantial gainful activity * * *.³

With regard to the evaluation of disability, the congressional committees were explicit in requiring the application of established national standards which were to be worked out in consultation with the State agencies. Thus, it was said:

By agreement, the State agencies will apply the standards developed for evaluating severity of impairments for purposes of the freeze. This will promote equal treatment of all disabled individuals under the old-age and survivors insurance system in all States * * *.⁴

REGULATIONS INTERPRETING "DISABILITY"

On the basis of the law and the intent of Congress as expressed through the various committee reports, the Social Security Administration has issued regulations defining the term "disability." These regulations appear in section 404.1501 of Social Security Administration Regulations No. 4 (20 CFR, sec. 404.1501) and read as follows:

"§ 404.1501 *Meaning of disability; benefits based on disability.*—

"(a) Among the requirements an individual must meet to be entitled to disability insurance benefits, or to child's insurance benefits after attainment of age 18, is that he be unable to engage in any substantial gainful activity because of a medically determinable impairment and that his impairment be expected to continue for a long and indefinite period of time, or to result in death.

"(b) In determining whether an individual's impairment makes him unable to engage in such activity, primary consideration is given to the severity of his impairment. Consideration is also given to such other factors as the individual's education, training, and work experience.

"(c) It must be established by medical evidence, and where necessary by appropriate medical tests, that the applicant's impairment results in such a lack of ability to perform significant functions—such as moving about, handling objects, hearing or speaking, or, in a case of mental impairment, reasoning or understanding—that he cannot, with his training, education, and work experience, engage in any kind of substantial gainful activity.

"(d) Whether or not the impairment in a particular case constitutes a disability is determined from all of the facts of that case. Examples of some impairments which would ordinarily be considered as preventing substantial gainful activity are set out in paragraph (e) of this section. The existence of one of these impairments (or of an impairment of greater severity), however, will not in and of itself always permit a finding that an individual is under a disability as defined in the law. Conditions which fall short of the levels of severity indicated must also be evaluated in terms of whether they do in fact prevent the individual from engaging in any substantial gainful activity.

³ S. Rept. 2133, 84th Cong., 2d sess. (1956), p. 133.

⁴ H. Rept. 1698, op. cit., p. 24; S. Rept. 1987, op. cit., p. 21.

“(e) The examples are:

“(1) Loss of use of two limbs.

“(2) Certain progressive diseases which have resulted in the physical loss or atrophy of a limb, such as diabetes, multiple sclerosis, or Buerger's disease.

“(3) Diseases of heart, lungs, or blood vessels which have resulted in major loss of heart or lung reserve as evidenced by X-ray, electrocardiogram, or other objective findings so that, despite medical treatment, it produces breathlessness, pain, or fatigue on slight exertion, such as walking several blocks, using public transportation, or doing small chores.

“(4) Cancer which is inoperable and progressive.

“(5) Damage to the brain or brain abnormality which has resulted in severe loss of judgment, intellect, orientation, or memory.

“(6) Mental disease (e.g., psychosis or severe psychoneurosis) requiring continued institutionalization or constant supervision of the affected individual.

“(7) Loss or diminution of vision to the extent that the affected individual has central visual acuity of no better than 20/200 in the better eye after best correction, or has an equivalent concentric contraction of his visual fields.

“(8) Permanent and total loss of speech.

“(9) Total deafness uncorrectible by a hearing aid.

((f) Under the law, an impairment must also be expected either to continue for a long and indefinite period or to result in death. Indefinite is used in the sense that it cannot reasonably be anticipated that the impairment will, in the foreseeable future, be so diminished as no longer to prevent substantial gainful activity. Thus, for example, an individual who suffers a bone fracture that has prevented him from working for an extended period of time will not be considered under a disability if his recovery can be expected in the foreseeable future.

“(g) Impairments which are remediable do not constitute a disability within the meaning of this section. An individual will be deemed not under a disability if, with reasonable effort and safety to himself, the impairment can be diminished to the extent that the individual will not be prevented by the impairment from engaging in any substantial gainful activity.”

THE DISABILITY INSURANCE STATE MANUAL

To assure uniform results throughout the Nation and at the same time promote equal treatment of all disabled individuals, it was necessary to develop evaluation standards as guides for determining whether or not an individual is disabled. The standards take into account the following:

(1) Statements by the congressional committees that considered the disability provisions of the OASDI program.

(2) Experience of other governmental agencies which administer disability programs (e.g., Veterans' Administration, Railroad Retirement Board).

(3) Advice of a Medical Advisory Committee, appointed in February 1955 by the Commissioner of Social Security, to provide technical advice on administrative guides and standards on

the evaluation of disability.⁵ (See Part VII of this "Fact Book" for details on this committee.)

These evaluation standards were incorporated in a manual—the Disability Insurance State Manual—which now serves as a guide in the adjudication of disability claims by operating personnel in the State agencies and the Division of Disability Operations. It provides a common source of information as to what factors should be considered in the adjudication of disability cases and promotes common understanding and uniformity. It is, however, only an internal guide for evaluating the severity of a disability and does not have the effect of law.

To explain the statute, the regulations, and the material in the State manual, the Department in the fall of 1958 issued a booklet, "Disability and Social Security" (OASI-29f), which contains a general description of the method for disability evaluation, the types of impairment which generally constitute disability, and the weight to be afforded the nonmedical factors. The pertinent portions of this booklet are presented in the following pages:

"DEFINITION OF 'DISABILITY'"

"INABILITY TO ENGAGE IN SUBSTANTIAL GAINFUL ACTIVITY"

"A person may become unemployed or remain unemployed for a number of reasons other than disability: individual employer hiring practices, technological changes in the industry in which the applicant has been employed, local or cyclical business or economic conditions, and many others. The disability provisions are intended to benefit only those persons who are not working because of incapacity, and not those unemployed because of these other factors.

"In order to qualify for a disability benefit or the freeze, the applicant must establish by medical evidence that his impairment results in such a lack of ability to perform significant functions—such as moving around, handling objects, hearing or speaking, or, in the case of mental impairment, reasoning or understanding, that he cannot, with his training, education and work experience, engage in any substantial gainful activity. It is not necessary that an applicant establish that he is helpless. On the other hand, it is not enough that he is unable to carry on his last or usual occupation.

"In general, a determination of disability depends upon the severity of the impairment and the extent of the handicap that it imposes on the particular applicant; it is made on the basis of the medical facts in the individual case and the worker's background and training. However, there are some obvious cases where the medical facts may be controlling. For example, where the only impairment is a moderate neurosis, moderate impairment of sight or hearing, or any other moderate abnormality, it would be obvious on the basis of medical considerations alone that the facts would not justify favorable determinations. Likewise, where the impairment is very severe,

⁵ In this connection this committee, on July 1, 1955, submitted a report with the following suggestion:

"The BOASI should issue evaluation guides and standards setting forth medical criteria for the evaluation of specific impairments and combinations of impairments, with the level of severity prescribed for each.

"Social, economic, educational, and other nonmedical factors may be important in the evaluation of disability in some cases."

'disability' as defined in the old-age, survivors, and disability insurance provisions, may be established (in the absence of work) on the basis of the medical facts."

* * * * *

"MEDICALLY DETERMINABLE

"A medically determinable impairment is an impairment that is determined to exist by a physician based on medical evidence and where necessary on appropriate medical tests.

"EXPECTED TO BE OF LONG-CONTINUED AND INDEFINITE DURATION OR
TO RESULT IN DEATH

"An impairment meets these requirements if it has persisted despite appropriate therapy for a period of not less than 6 months and if it cannot reasonably be anticipated that the impairment will in the foreseeable future be improved to the point that it will no longer prevent substantial gainful activity. However, the possibility that through new discoveries in medical science or rehabilitation techniques the applicant may be able to engage in substantial gainful activity in the future does not mean that the condition may not be expected to be of long-continued and indefinite duration.

"An impairment is considered 'likely to result in death' if, on the basis of established medical knowledge, it is found to be in a terminal stage under the particular circumstances of the case, considering the age, medical history, and the medical condition of the individual.

"REMEDIABLE CONDITION

"A condition that is remediable by generally accepted therapy to the extent that it would no longer prevent the applicant from engaging in substantial gainful activity is not considered to be disabling. However, a condition is considered remediable only if the therapy does not involve significant risk to the life or health of the patient.

"EVIDENCE OF DISABILITY

"The burden of establishing the existence and duration of disability is on the applicant. Opinions regarding prognosis or functional capacity expressed by the applicant's medical sources are not conclusive. If submitted, they should be supported by an adequate summary of the history, course, findings and reasons for the opinion.

"An applicant must furnish evidence based upon examinations made by a qualified medical examiner to establish the nature and severity of his impairment from the time he claims it prevented him from engaging in substantial gainful work. The Department of Health, Education, and Welfare may, under certain circumstances, purchase medical evidence to reconcile discrepancies in the proof, obtain more detailed findings, etc. However, this may be done only after the applicant has furnished sufficient evidence to establish the reasonable likelihood of disability.

"The medical evidence submitted by the applicant should contain an adequate summary of the history, diagnosis, physical and clinical findings, treatment, and response. The clinical facts must be adequate

to confirm for the reviewing physician the diagnosis, and to describe the severity of the condition, the response to therapy, and the applicant's residual physical or mental capacity. Where appropriate, the applicant's physician is expected to supply results of tests that he has made to establish the diagnosis or describe the applicant's capacity to function. Where an applicant has been examined in connection with an application for benefits under another disability program or has been hospitalized or institutionalized, the report of such findings or treatment is acceptable in support of the applicant's claim. In many cases the Department will be able to assist an applicant to obtain copies or summaries of medical records.

"EFFECT OF DETERMINATION OF DISABILITY MADE BY ANOTHER AGENCY

"A decision of another agency that an individual is totally or totally and permanently disabled is not controlling. The evaluation team¹ must make an independent determination under the law and it is not authorized to find the applicant disabled unless in its judgment the evidence supports such a finding.

"Therefore, an applicant for disability insurance benefits who has been allowed a benefit under another program should submit the report of the examination made for the other agencies, as well as the decision. In making its decision, the evaluation team considers the evidence underlying the decision of the other Government agencies.

"DISABILITY EVALUATION GUIDES

"Under the disability provisions, the determination of disability must be made on the basis of the facts in the individual's case. The law does not authorize the use of a rating schedule or the adoption of an 'average man' concept of total disability. The question in every case is whether the individual in spite of his impairment has sufficient capacity to function so that considering his age, education, and experience, he is able to engage in any substantial gainful activity. This requires evaluation of the severity of the impairment and of its effect upon the applicant, and finally, consideration of the applicant's education and experience so that it can be determined whether there remains a capacity to engage in any substantial gainful work.

"The Department has developed medical guides for evaluation teams in the State agencies and in the central office. The medical guides were prepared with the assistance of a national Medical Advisory Committee. They are supplemented by technical training and discussion and are constantly being reviewed and revised in the light of the Department's experience to make them more useful to evaluators. An objective of the guides is to promote equal treatment for all applicants throughout the country.

"These medical guides are essentially clinical descriptions of a number of impairments that may be totally disabling from the point of view of anatomical damage or functional loss, arranged according to the body system primarily involved. Primarily, the discussions include a description of the symptoms and the clinical and laboratory

¹ Determinations of disability are made by evaluation teams (including a physician and a vocational specialist) in State agencies (usually the State vocational rehabilitation agencies) under agreements with the Secretary of Health, Education, and Welfare. In those cases in which the applicant lives outside the United States or where his case is excluded from the agreements, the case is adjudicated in the central office of the Bureau of Old-Age and Survivors Insurance in Baltimore.

findings that may indicate that a disease process has reached such an advanced stage that most people so affected would not have sufficient vitality or understanding to perform any kind of substantial work. However, it is not possible to describe all conditions which are disabling. Moreover, the effects of a given impairment will vary as between individuals, and the vocational limitations imposed by a particular condition will depend upon the applicant's age, education, and previous experience. Thus, there will be cases in which an applicant with a condition described in the guides will nevertheless not be disabled within the meaning of the law because as a result of special skills or for other reasons, he was able to, or actually did, engage in substantial gainful activity despite a severe impairment.

"On the other hand, there is no requirement that the applicant have a single condition or combination of conditions comparable in severity to those described in the medical guides. Conditions that fall short of the severity of those described in the guides are evaluated in terms of whether in fact they prevent the applicant from engaging in any substantial gainful activity. The guides facilitate identification of clear-cut cases of what might ordinarily be inability to engage in substantial gainful activity.

"MEDICAL FACTORS IN EVALUATING DISABILITY

"Below are listed, by body system, descriptions of impairments most frequently encountered and which most frequently result in disability. Malignancies are omitted because the condition may be associated with any of the body systems. An individual with a malignancy which is progressive and untreatable may be disabled regardless of the body system involved.

"1. MUSCULOSKELETAL SYSTEM

"The musculoskeletal system provides support to the body as a whole, protects vital organs, and performs the normal movements involved in working for a living; such as walking, stooping, bending, reaching, lifting, grasping, etc. Pertinent history, physical, X-ray, and laboratory findings are important in documenting the extent of remaining function.

"The following general considerations apply in evaluating remaining function in the case of impairments of the musculoskeletal system:

"(1) Remaining capacity for weight-bearing in standing or sitting posture and ambulation; the extent of ability to walk, stand, or sit and maintain this posture. (2) Capacity for handiwork; the ability to perform gross or fine movements of arms, hands, and fingers. (3) Underlying systemic diseases; the existence of an underlying systemic disease, such as diabetes mellitus, cardiovascular, or infectious disease may aggravate the degree of impairment. (4) Prosthesis; the ability to wear and use an artificial limb.

"(a) *Loss of (or loss of use of) two limbs; of one limb*

"Loss of (or loss of use of) a part may be caused by injury or disease resulting in deformity, adhesions, defective innervation (nerve damage), or other pathology. Where an individual has lost the use of two limbs, he would generally be considered unable to engage in any substantial gainful activity. Loss of (or permanent loss of use of) one

lower extremity may be disabling where the loss resulted from a progressive systemic disease (diabetes, multiple sclerosis, or Buerger's disease).

“(b) Arthritis

“These impairments should be described in such detail that an evaluator will be able to assess accurately the limitation of function. The clinical evidence should include history, physical findings, and laboratory data, including X-ray where indicated, treatment, and response. It is preferable that results of laboratory tests and descriptions of X-rays be furnished, rather than interpretations alone. The applicant and his physician should also describe the remaining ranges of motion in affected joints, and any deformities that may exist.

“These conditions may result in disability where the disease involves bilateral joints to such a degree that the condition interferes severely with standing and walking, or hand manipulating, or where the disease results in severe constitutional complications.

“2. SPECIAL SENSE ORGANS

“In this category we include the organs of vision and hearing. In measuring visual efficiency the primary factors are central visual acuity, field of vision, and muscle function. The determination of visual capacity depends upon findings made by a competent medical examiner based upon accepted methods of measuring visual efficiency.

“(a) Visual acuity

“Measurement of visual acuity is based upon the best corrected central visual acuity for distance, generally using Snellen's test letters. Field of vision should be measured, preferably by use of the perimeter.

“Generally, persons who have central visual acuity no better than 20/200 in the better eye after best correction (or contraction of visual fields to 15 degrees or less) are ‘industrially blind,’ and may be disabled.²

“(b) Auditory impairments

“Auditory efficiency is evaluated on the basis of auditory testing using a suitable hearing aid. The evaluation of auditory capacity is based on the applicant's best capacity with the use of a suitable aid. A person who has incurred a disease or injury resulting in absence of airnerve and bone conduction in both ears not improvable by hearing aid may be unable to engage in substantial gainful activity. Auditory perception of not more than one pure tone at high volume would not rebut a finding of total loss of hearing. Advanced diseases of the inner ear which result in severe and frequent vertigo, nausea, progressive deafness, and cerebellar gait (staggering) may be totally disabling.

² “Blindness” is defined in sec. 216(i) of the Social Security Act; “central visual acuity of 5/200 or less in the better eye with the use of a correcting lens. An eye in which the visual field is reduced to 5 degrees or less concentric contraction” is considered as having central visual acuity of 5/200 or less. A person having a visual efficiency no better than that described in this definition must be considered “disabled” for purposes of the disability freeze without considering his actual ability to engage in any substantial gainful activity. For purposes of disability benefits, a person must demonstrate inability to engage in any substantial gainful activity regardless of the degree of visual impairment.

"3. RESPIRATORY IMPAIRMENTS

"Loss of respiratory function may result from interference in ventilatory capacity, i.e., the delivery of oxygen to the air cells in the lungs (alveoli) or it may result from interference in diffusion (the actual exchange of gas across the membranes of the air cells). The mechanism by which the breathing function is damaged is varied and depends upon the disease involved. Among the most common respiratory diseases are tuberculosis, emphysema, pneumoconiosis, such as silicosis or anthrasilicosis, bronchiectasis (a disease causing abnormal enlargement of the air passages) and pulmonary fibrosis (a scarring of the lung tissue from repeated infections or degenerative changes).

"In these diseases, the handicap results from the inability of the respiratory mechanism to supply sufficient oxygen to meet demands. The extent of handicap depends upon the degree of interference with oxygen supply. Most if not all the above diseases may interfere with ventilation, that is, the movement of air in and out of the lung. Ventilation impairments may be evaluated on the basis of history, physical, and laboratory findings exclusive of ventilatory tests in some instances. In most instances ventilatory tests, such as vital capacity and timed vital capacity, are the preferred tests for helping evaluate the extent of remaining capacity. Some diseases impair diffusion capacity—ability of oxygen to pass through the lung membrane or into the bloodstream. In these conditions, ventilatory function may be normal, that is, there may be normal, or relatively normal, ability to move air in and out of the lung, but the capacity to pass the air across the lung membrane and have it carried away by the bloodstream may be so reduced as to make it impossible for an individual to engage in substantial gainful activity. Diffusion capacity or oxygen consumption capacity is difficult to measure. In spite of technical difficulties, testing of the applicant's ability to consume oxygen may at times be the most accurate way of arriving at a quantitative estimate of the individual's impairment.

"(a) *Pulmonary tuberculosis*

"Methods of treatment of pulmonary tuberculosis have changed substantially in recent years. As a result, recovery and return to gainful employment may reasonably be expected in most cases. These conditions may be totally disabling while they are active, but they are generally not long lasting. Where the condition has reached a point of stability or improvement and there is no evidence of severe loss of pulmonary function, the individual is generally on the road to recovery and return to substantial work is usually foreseeable. Therefore, where the medical evidence indicates that sputum tests are negative and serial X-rays indicate that there is no cavitation and that the infiltration has remained stationary or is decreasing, it will generally be considered that the disease would not be expected to be long lasting.

"On the other hand, moderately advanced or far-advanced pulmonary tuberculosis which has persisted for at least 6 months and in which the X-rays reveal cavitation or progression, or where the sputum is persistently positive, would be considered long lasting, since recovery cannot reasonably be predicted in the foreseeable future.

“(b) Other conditions resulting in pulmonary insufficiency

“Pneumoconiosis, asthma, emphysema, bronchiectasis, and pulmonary fibrosis: The medical information obtained from the applicant and from his physician in such cases should indicate the anatomical and physiological results of the disease, that is, the extent to which activity produces symptoms of fatigue and shortness of breath. The tests which actually demonstrate the applicant's remaining capacity are standardized exercise tolerance tests, timed vital capacity, blood carbon dioxide and hematocrit. In diseases characterized by fatigue, attacks of coughing, and where symptoms are periodic, the frequency and severity of the attacks and remediability serve as indirect evidence of capacity or incapacity for work.

“An individual with severe pulmonary insufficiency may be unable to engage in any substantial gainful activity if the condition results in such impairment of pulmonary reserve that it produces shortness of breath on mild exertion (such as walking several blocks, using public transportation, and doing small chores).

“(c) Loss of speech

“Organic loss of speech due to laryngectomy, central nervous system damage, or other cause may be disabling.

“4. CARDIOVASCULAR SYSTEM

“Special care is necessary in evaluating pain in cases of alleged heart disease because there are many other diseases which mimic the pain caused by heart disease. In the majority of such imitators activity is harmless. In many of them pain is preventable or alleviated by prompt treatment. For example, the pain caused by hiatus hernia (upside-down stomach). In a few of them, activity is actually beneficial. For example, rheumatoid arthritis after the acute stage.

“The handicap imposed by heart disease ranges from none to total. Some persons with heart disease causing mild pain or breathlessness restrict all activity for fear of causing further harm. But in the great majority of people with heart disease activity consistent with some types of work is harmless. Usually it would not be detrimental for people with heart disease to continue to engage in any level of activity that does not produce symptoms of cardiac embarrassment. Therefore, evidence that a physician has advised an applicant to restrict his activity should be supported by the doctor's reasons.

“There is no single test that measures accurately an individual's capacity to work in the presence of heart disease. Activity limitations imposed by heart disease depend on the type of disease and its response to therapy.

“In making an evaluation of work capacity in the presence of heart disease, the evaluation team must have sufficient evidence to enable it to make an independent determination as to the type of disease and the degree of activity which produces symptoms most frequently.

“Generally either pain or breathlessness (shortness of breath) during varying degrees of exercise are usually the only work-limiting symptoms of which the patient is aware. In addition to these symptoms the evidence must describe the disease. Such evidence usually appears in terms of significant history, physical findings, or laboratory data. In heart disease, the latter usually includes electrocardiogram, chest

X-rays in various positions, or fluoroscopy. In all instances, reports of laboratory findings are preferred to interpretations, although both are even better. Although there are many causes of heart disease, disability, when it exists, is ordinarily caused by one of two principal consequences of the disease. The first is congestive heart failure and the other is pain. Disability may exist if the individual's cardiac reserve has been so impaired that significant and persistent symptoms of cardiac disease appear when he engages in slight activity such as walking several blocks, using public transportation, or doing small chores.

“(a) Congestive heart failure

“Congestive heart failure may be characterized by cardiac enlargement, shortness of breath, and fluid in the tissues. An individual may be unable to engage in any substantial gainful activity where the clinical evidence establishes the persistence of chronic congestive heart failure despite therapy.

“(b) Arteriosclerotic heart disease or coronary artery disease

“Arteriosclerotic heart disease is by far the most common cause of cardiovascular disability and heart muscle damage or death. The degree of disability may range from none to total, depending upon the signs and symptoms produced by activity. Angina is a symptom that may be produced by arteriosclerotic heart disease. In the presence of arteriosclerotic heart disease, evaluation of the severity of the condition depends upon the frequency of the pain, the kind and degree of activity that produces the anginal attacks, and the response of the condition to accepted therapy. The presence or absence of electrocardiogram changes may be significant. Important elements that evaluation teams explore are the history, effect of exposure to cold, effect of activity, type and the severity of the pain. A myocardial infarction (heart attack) is evaluated on the basis of remaining work capacity after the healing period.

“(c) Hypertensive vascular disease (high blood pressure associated with circulatory disease)

“Hypertensive vascular disease would not generally prevent a person from engaging in substantial gainful activity until it becomes severe enough to cause serious complications in one or more of the four main end-organ systems: i.e., the heart, the brain, the kidneys, or the eyes. The heart may be damaged as a result of the failure of the blood vessels to supply it with sufficient food and oxygen or it may become damaged because of the added burden imposed by the diseased blood vessels. The brain may be affected by cerebral thrombosis or hemorrhage, resulting in hemiplegia (paralysis of one side), speech difficulty or psychosis; the kidneys may be damaged; the retinas of the eyes may be damaged as a result of the disease of the retinal blood vessels. These effects may occur singly or in combination and to varying degrees in the different organ systems. When the heart is involved, either with or without infarction (heart attack), the patient may develop the usual symptoms of coronary artery disease; manifested as either angina or shortness of breath. In evaluating the impairment of an individual with hypertensive vascular disease, the examiner considers the following elements: (1) existence or absence of persistently elevated diastolic pressure; (2) existence or

absence of cardiac enlargement or symptoms of congestive heart failure; (3) existence or absence of renal failure; (4) existence or absence of retinal or brain damage.

“(d) *Peripheral vascular disease (disease of the blood circulation system involving the extremities)*

“The major consideration in evaluating circulatory diseases affecting the extremities is the degree to which the condition impairs ambulation. Evaluation depends in part upon the history and symptomatology, but these are generally confirmed by objective findings such as X-ray evidence of calcification, contrast media studies of vascular occlusion, other appropriate laboratory studies, and neurological findings such as sensory loss, atrophy, abnormal reflexes, absence or decrease in pulsation in the lower limbs (femoral popliteal or posterior tibial).

“Inability to engage in substantial gainful activity may result where the applicant has progressive vascular disease (arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's disease)), which has resulted in the loss of use of one lower extremity or which results in inability to carry on such slight exertion as climbing stairs or walking several blocks.

“5. DIGESTIVE SYSTEM

“Diseases and disorders of the digestive system which interfere with proper food intake, digestion or excretion may prevent proper body nutrition. The diseases of the digestive system may result in malnutrition, evidenced by loss of weight, loss of muscle strength, or severe pain. In evaluating capacity to work in cases of applications involving impairment of the digestive system, the evaluation team considers the following:

“(a) Severity of anemia, malnutrition or loss of strength despite therapy;

“(b) Existence of ascites (fluid in abdominal cavity), bleeding from digestive system, or other signs of advanced disease unrelieved by therapy;

“(c) Residuals of surgical intervention (e.g., colostomy, ileostomy) and manageability of device.

“6. GENITO-URINARY SYSTEM

“Genito-urinary conditions that result in inability to engage in any substantial gainful activity arise from disturbances of kidney or bladder function. However, these conditions vary in severity from absence of symptoms to total disability.

“An individual may be unable to engage in any substantial gainful activity where there is persistent fluid in the tissue (edema) resulting from kidney disease or when severe impairment of kidney function is demonstrated by tests that reveal (a) extensive and persistent inability of the kidneys to excrete waste materials; or (b) extensive and persistent urinary excretion of substances usually absorbed by the kidneys. Significant impairment of kidney function may be demonstrated by elevated retention of nonprotein nitrogen (NPN) or urea clearance of phenol red (phenolsulfonphthalein) (PSP), dilution-concentration and specific gravity tests.

"7. HEMIC AND LYMPHATIC SYSTEM (BLOOD AND LYMPH)

"Diseases of these systems may exhibit acute or chronic form. In some cases, the individual is able to work during early phases of the disease or periods of remissions, but as the disease progresses work capacity may be lost. The history, course, and the constitutional symptoms in each case should indicate whether or not work capacity remains. Long-term inability to engage in any substantial gainful activity may occur in cases involving advanced stages of such conditions provided that they are not amenable to accepted therapy and that there are severe constitutional symptoms.

"8. ENDOCRINE SYSTEM

"Under this category we include hormone disorders. Among the hormones involved in disabling conditions are those of the adrenal, parathyroid, and pituitary glands and the pancreas. The growth of scientific knowledge in the field of endocrinology makes it necessary to consider the effect of newly discovered treatment. The availability of these treatments is considered by the evaluation team in determining whether the condition is remediable. Moreover, not all patients respond equally or satisfactorily to these therapeutic measures. A condition which has not responded after adequate trial is not considered remediable.

"Diabetes mellitus usually responds to management by diet, alone or together with administration of insulin. With the passage of time or when control of the condition is inadequate, the condition may result in damage to the lower extremities, the eyes, the nerves or the kidneys. The functional impairment present in the end organs affected is evaluated. An individual may be considered disabled if he has diabetes and if despite therapy the condition is complicated by gangrene in his extremities resulting in loss of use or severe retinopathy resulting in loss of vision.

"Other endocrine disorders may be totally disabling where severe constitutional symptoms such as severe anemia, fatigue, and loss of weight prevent work and persist in spite of therapy.

"9. BRAIN AND NERVOUS SYSTEM

"Disorders of the brain and nervous system include both organic (resulting from disease or injury) and functional (nonorganic) conditions (conditions in which damage to the brain or nerves cannot be demonstrated).

"These diseases may result in impairment of the individual's ability to move, stand, manipulate, etc.; damage to his sensory apparatus; impairment of reasoning, judgment, idea formation, memory, etc. As in cases involving other body systems, there is a wide range in the handicaps resulting from the varying degrees of severity of these conditions.

"(a) *Neurological disorders*

"Among these disorders are epilepsy, cerebral arteriosclerosis, Parkinson's disease, poliomyelitis, multiple sclerosis, cerebral palsy, muscular dystrophy and some others. Cerebral arteriosclerosis may occur either as a slowly or more acutely progressive condition. It is the most frequent but not the only cause of 'stroke' or cerebrovascular

accident (cerebral hemorrhage or cerebral thrombosis) which may result in paralysis or partial paralysis. Strokes may cause other damage to the nervous system (e. g., affecting speech, sensation, etc.). The extent of recovery of function after a cerebrovascular accident depends on the extent of brain damage. The degree of ultimate recovery of functions can usually be predicted after 6 months have elapsed.

"Cerebral arteriosclerosis may be part of a generalized arteriosclerotic condition. In such cases, it is not uncommon to find evidence of heart and kidney involvement. All these complications are considered in evaluating severity of impairment. Persons who suffer from cerebral arteriosclerosis may also exhibit symptoms of loss of ability to concentrate, memory defects, insomnia, etc. Some or all of these may influence the patient's physical or mental capacity and his ability to engage in substantial gainful activity.

"(b) Epilepsy

"It is preferable to have a thorough examination confirming the diagnosis, and objective medical evidence of witnessed convulsive seizures before and after accepted therapy. Electroencephalographic tracings or report of findings should be obtained. Persons who have repeated closely associated seizures despite treatment may be disabled.

"(c) Anterior poliomyelitis

"As in other acute diseases, these cases are evaluated on the basis of the permanent residuals. Individuals may be totally disabled by reason of this disease where they are so severely paralyzed that their ability to walk, stand, lift, or manipulate is severely impaired.

"(d) Other conditions

"Likewise, total disability may result from other conditions, such as cerebral palsy, muscular dystrophy, Parkinson's disease, multiple sclerosis, where there is severe impairment of ability to walk, stand, manipulate, lift, etc.

"(e) Psychiatric conditions (organic psychiatric disorders; functional disorders: e.g., psychosis, psychoneurosis, personality disturbance and mental deficiency)

"The neurosis or psychosis represents the individual's attempt to adjust to the various psychological and social forces with which he deals or his failure to make that adjustment. Psychiatric disorders may be classified into three groups: (1) caused by or associated with damage to brain tissue (organic brain syndrome); (2) without clearly defined structural change in the brain, but of psychogenic (psychological) or functional origin (psychoses, psychoneurosis, personality disorders); and (3) mental deficiency.

"(1) Organic brain syndrome.—The following symptoms may be associated with organic brain syndrome: impairment of memory, orientation, reasoning, judgment and feeling tone (affect). These reactions have an 'organic' basis; that is, they result from known disease or injury. They may result from a large number of causes including disturbance of growth, nutrition, drug, brain injury, or cerebral arteriosclerosis. Among the conditions are: senile psychosis; traumatic psychosis; Korsakow's disease; Pick's disease; Alzheimer's disease.

"(2) *Functional mental illnesses (psychoses, psychoneuroses, personality disorders)*.—These reactions do not have known organic basis; they are referred to as 'functional.' They include mood disorders such as manic depressive and depressive reactions; schizophrenic disorders; and paranoid states. In view of advances in treatment of these conditions, such conditions frequently respond dramatically to treatment. Spontaneous remissions also occur.

"(a) Psychoses: These conditions usually require hospitalization. Where the condition has resulted in hospitalization for at least 6 months and has not responded to therapy, it may be disabling.

"(b) Psychoneuroses: In these disorders there is no break with reality. These reactions are manifested by anxiety, hostility, insecurity, fear, and tension. In some cases of neurosis, the physical results alone may be disabling and not amenable to therapy; for example, hysterical paralysis of two limbs, hysterical total blindness or other such severe disorder that mimics body system disease. If the condition results in immobilization or confinement to a mental hospital and persists despite appropriate therapy, it may be disabling. To assure fair evaluation, an adequate psychiatric examination is necessary.

"(c) Personality disorders: These manifest themselves in alcoholism, sexual deviation, drug addiction, and other antisocial or maladjusted behavior. These manifestations themselves do not destroy all ability to engage in any substantial gainful activity unless there is an associated severe psychotic reaction or severe psychoneurosis. Persons imprisoned because of antisocial behavior resulting from a mental disease are not eligible for benefits unless they would be unable to engage in any substantial gainful activity if they had not been imprisoned.

"(3) *Mental deficiency*.—Evaluation of the degree of impairment of a mentally retarded individual is generally made on the basis of an accepted intelligence test (such as Binet-Stanford or Bellevue-Wechsler) and in borderline cases on the evidence of the individual's ability to socialize and his occupational competence. The intelligence test should be administered and interpreted by qualified psychologists or psychiatrists. The test should reflect the individual's condition as of age 16 or over. Persons with a mental age of 7 or less and those requiring institutionalization may be disabled.

"OTHER FACTORS IN EVALUATING DISABILITY

"The following are additional factors that influence the extent of handicap imposed by an impairment.

"AGE

"An impairment may be more limiting for an older person than for a younger person. The aging process affects healing, prognosis, psychologic adaptability, general health, speed and efficiency.

"As indicated above, a person generally suffers physiological impairment due to the aging process. In addition, employers may have prejudice against hiring older workers. This prejudice may cause a man to be unemployed, but it does not make him unable to do substantial work by reason of a medical impairment. The medically determinable impairments are the primary facts the evaluation team considers in evaluating the handicaps.

"EDUCATION

"The amount of education a person has is a factor in determining his adaptability to other occupations if he should become unable to perform his usual occupation. However, lack of formal schooling is not necessarily proof that the applicant is uneducated or not adaptable.

"EXPERIENCE

"A person who all his life has done simple unskilled work may find it difficult to adjust to a different occupation if he acquires a handicap which interferes with his ability to carry on the work in which he is experienced. Limitation to unskilled work, especially when paired with limited education, may indicate limited vocational adaptability. On the other hand, an educated person who has varied experience very often is able to make adjustments more readily.

"EFFECT OF RETRAINING OR REHABILITATION

"A major object of the disability benefit provision is to promote the restoration of handicapped individuals to gainful work. Efforts toward rehabilitation should not prejudice a person's right to a benefit. Therefore, an applicant may be considered to be under a 'disability,' despite efforts on his part to be retrained or to be otherwise rehabilitated.

"Employment for a period up to 12 months would not by itself demonstrate ability to engage in substantial gainful activity, provided the work was performed pursuant to a rehabilitation plan established by a State agency under the Federal-State rehabilitation program.

"WORK TO DETRIMENT

"Where a substantially impaired individual performs work that is medically contraindicated, this would not, of itself, demonstrate ability to engage in substantial gainful activity. However, where an applicant has continued to work and his condition has not been aggravated and has not deteriorated, it will be considered that the work was not detrimental.

"SUBSTANTIAL GAINFUL ACTIVITY

"When a handicapped individual works, the issue may arise as to whether he has thereby demonstrated that he is able to engage in substantial gainful activity.

"Substantial gainful activity means the performance of substantial services with reasonable regularity in some employment or self-employment. It relates to the range of activities the individual is able to perform. However, complete helplessness is not necessary to a finding of allowable disability. Sporadic or infrequent activity would not necessarily establish ability to engage in substantial gainful activity. In determining whether the work by an applicant rebuts disability, the following factors are considered:

"(a) *Nature of activities*

"The physical and mental demands of the employment or self-employment.

“(b) Regularity of work

“Regularity or continued performance of substantial work over an extended period of time strongly points to a determination that the applicant is able to engage in substantial gainful activity. On the other hand, a contrary conclusion might be indicated where, due to the impairment, excessive time is lost, or there is unsatisfactory performance, or the work is temporary. The number of hours the individual is able to work with his impairment is especially significant. Sporadic or occasional periods of work do not necessarily indicate ability to engage in substantial gainful activity.

“(c) Earnings

“In determining whether an individual is engaging in substantial gainful activity, a factor to be considered is his earnings rate. Income from nonwork sources, as distinguished from earnings from work, is not considered in evaluation of substantial gainful activity. Demonstration of capacity to work regularly and substantially by a self-employed person would rebut disability even though he operates at a loss.

“(d) Return to work after allowance of disability although condition has not substantially improved

“Where evidence that an individual has returned to work is sufficient to establish that he has regained ability to engage in substantial gainful activity in a particular month, his benefits must be terminated in that month. The return to work of an individual, however, does not in and of itself establish that he has regained the ability to engage in any substantial gainful activity. The work effort of a seriously disabled individual may have to be sustained for as long as 3 months, or perhaps even longer, in order to demonstrate that his ability to engage in substantial gainful activity has been restored. Where it appears that he has not yet regained his ability to engage in substantial gainful activity, payment of his benefits need not be suspended while development of the facts surrounding his work activity is going on. If a determination is made that disability has ceased, this must be effective for the month in which ability to engage was regained. It may be found that the month of termination may coincide with the first month of suspension but the specific facts in the given case may require a finding that the termination shall take place in an earlier month or a later month.

“Where a severely impaired individual has attempted to work, but after a limited trial period has not been able to sustain his activity because of impairment, this tends to indicate that he continues to be unable to engage in substantial gainful activity.

“(e) Inability to engage in substantial gainful activity after successful work effort

“An individual whose benefits had been terminated because he had returned to substantial work over a long period of time may subsequently find that he is no longer able to carry on substantial gainful activity. Where an individual whose ability to work had been restored is again compelled to stop working because of his impairment, he may be disabled from the date he last became unable to engage in any substantial gainful activity. However, he would have to wait 6 months before he would again receive monthly benefits.”

PART IV

DISABILITY OPERATING EXPERIENCE: STATISTICS AND SUMMARY

SUMMARY OF SELECTED WORKLOAD AND BENEFIT DATA ON DISABILITY OPERATIONS

The disability "freeze" provisions of the Social Security Act have now been in effect for almost 5 years. Cash disability benefits for disabled workers aged 50 to 65 and for disabled children 18 or over were added by the 1956 amendments. The 1958 amendments extended benefits to certain dependents of workers entitled to cash disability benefits. Some of the highlights of the disability program to date are summarized below:

a. Workload highlights (cumulative through end of May 1959):	
A. Number of disability determinations.....	1, 137, 800
B. Number of cases allowed (62 percent of number in A).....	708, 100
(i) Allowed on initial determination (94 percent).....	666, 000
(ii) Allowed on reconsideration or hearing (6 percent).....	42, 100
C. Number of cases disallowed because of failure to meet disability test (38 percent of number in A).....	¹ 429, 700
D. Requests for reconsideration received.....	122, 400
(i) Reconsideration determinations made....	111, 000
(ii) Number allowed after reconsideration (31 percent of the number in (i)).....	34, 200
E. Requests for hearing received.....	37, 800
(i) Number of requests in which action has been taken.....	27, 000
(ii) Total number of cases allowed (29 percent of the number in (i)).....	7, 900
(a) Number of cases allowed by Bureau after remand by referee (before hearing) (24 percent)...	6, 400
(b) Number of cases allowed by referee (after hearing) (5 percent).....	1, 500
F. Allowed cases subsequently examined for possible issue of continuing disability.....	334, 000
(i) Number of determinations of continuing disability.....	315, 600
(a) Number of cases resolved by evidence in file.....	190, 400
(b) Number of field investigations.....	125, 200
(ii) Cases terminated (5 percent of number in (i)).....	17, 100

See footnotes at end of table, p. 36.

b. Pending workloads (end of May 1959):

A. Applications pending initial determination:

	Total	Disability insurance benefits	Freeze	Childhood disability
(i) In all places-----	120,700	81,400	29,000	10,300
(ii) In Bureau's district offices--	45,600	30,500	11,600	3,500
(iii) In State agencies-----	57,100	40,700	10,900	5,500
(iv) In Bureau's central office--	18,000	10,200	6,500	1,300

B. Reconsideration requests pending----- 11,400

C. Hearing requests pending----- 10,800

D. Investigations pending on issue of continuing eligibility-- 18,400

c. Benefit highlights (end of May 1959):

A. Number of persons receiving benefits under the disability

program, end of month----- 502,500

(i) Number receiving disability insurance benefits----- 268,800

(ii) Number receiving benefits as dependents of disabled workers----- ² 77,700

(iii) Number receiving childhood disability benefits----- 61,000

(iv) Number of old-age and survivor insurance beneficiaries receiving higher benefits as a result of a disability freeze----- 95,000

B. Average monthly benefits paid to disabled workers----- \$88

C. Average monthly benefits paid to childhood disability beneficiaries----- \$43

D. Number of disability periods ("freeze") in effect for persons under age 50 (estimated)----- 100,000

d. Vocational rehabilitation referral program: Actions on OASDI referrals (nonapplicants and applicants) reported by State vocational rehabilitation (VR) agencies:

A. Total cases (all applicants and nonapplicants) referred by OASDI for VR services (cumulative through end of June 1959)----- 1,310,122

B. Number of cases in A above selected (as of end of June 1959) for further VR consideration----- 140,900

C. Total cases reported as rehabilitated through end of June 1958----- ³ 2,200

¹ An additional 312,700 cases (not included in items A or C) were disallowed for reasons other than the individual's failure to meet the disability test—e.g., the individual lacked an insured status; the individual did not submit evidence as to his disability.

² Excludes about 600 individuals receiving childhood disability benefits who are also dependents of disabled workers.

³ Data not available on the proportion of the 2,200 rehabilitated that represent applicants whose disability claims were allowed. However, later data suggests that the proportion would be around 25 percent.

DISABILITY OPERATING EXPERIENCE

GENERAL

The 1954 amendments to the Social Security Act provided for establishing a disability "freeze" for persons who were under a disability on July 1, 1955, or thereafter, on the basis of applications filed beginning January 1955. The administration of this provision required that the Bureau establish an effective working basis for a novel kind of governmental relationship providing for State agency determination of disability for a Federal program purpose; that it bring into being an administrative framework and assemble the technical skills needed to handle the complex problem of disability evaluation; and that it establish policies and procedures that would lead to uniform treatment of all applicants regardless of where they filed their claims. Furthermore, the administration of this new program required the establishment of new areas of relationships with other Federal agencies concerned with disability and related programs, with the medical profession and other professional groups.

The disability program has been significantly amended twice, in 1956 and 1958. Each set of amendments posed administrative problems. The addition of new types of disability claims, particularly the cash benefit provisions made applicable to a large backlog of previously disabled persons, caused high pending loads and delays in the processing of cases. The Bureau states that by now, most of the backlog of older cases has been worked out. As the result of reductions in pending loads, coupled with steps taken to effect improvements, the time required to process a case to payment or denial has been cut about in half from what it was 2 years ago.

From the beginning of the disability program to the end of May 1959, just over 1.1 million disability determinations had been made; 62 percent of these determinations were allowances while 38 percent were denied by reason of lack of severity of the applicant's impairment. An additional 312,700 cases not included in the above totals have been denied for nonmedical reasons, such as insured status requirements (see Part IX of this Fact Book) not met at any time or medical evidence not submitted by the applicant.

One-half million persons are currently drawing old-age, survivors, and disability insurance benefits where either the eligibility was established or the amount of the benefit increased by a determination of disability. In addition, approximately 100,000 disabled persons under 50 years of age are in "freeze" status, i.e., their social security wage record and future benefit rights are protected. The current disability roll is a changing one, affected not only by the addition of new claims but by deletions resulting from such events as death, transfer to the old-age insurance beneficiary rolls at age 65, and cessation of disability. Specifically, for the month of May 1959, approximately 269,000 disabled workers received disability insurance benefits and 78,000 dependents of these workers also received benefits. In addition, 95,000 old-age and survivors insurance beneficiaries (excludes disability beneficiaries) were receiving higher monthly benefits as a result of the disability "freeze." Finally, about 61,000 individuals, age 18 or over, who are either dependents or survivors of insured workers, received childhood disability benefits for May 1959.

The statement which follows highlights some of the significant aspects of the disability operating experience to date.

PREPARING FOR DISABILITY OPERATIONS IN THE STATES

Soon after the passage of the 1954 amendments, negotiations were undertaken to secure agreements with the States to make disability determinations and to establish the basis for providing Federal funds to cover the cost of setting the State disability operation in motion. While three-fourths of the State agencies had signed agreements by June 1955, agreements were not effected with all States and Territories until early in 1956. In some States, negotiation of the agreement had to await enabling legislation or an opinion from the attorney general of the State.

With the signing of the State agreement, each agency faced the task of setting up a disability organization, recruiting and training staff to make determinations of disability, and working out operating methods to process its volume of cases. As many of the agencies (mostly vocational rehabilitation agencies) were concurrently expanding their own programs, many problems and some delays had to be overcome. In general, the single biggest difficulty was that related to the recruitment of sufficient qualified personnel, including medical consultants, under State regulations and practices governing the employment of State personnel.

DISABILITIES COVERED BY STATE AGREEMENTS

The initial disability "freeze" provisions resulted in a large backlog of cases because workers who became disabled as far back as 1941 could qualify for a "freeze."

Anticipating the difficulties in setting up disability operations, the agreements in 39 States did not cover the entire backlog of disability cases at the time the original agreement was signed. Generally, agencies in these States agreed that the Bureau would process those cases where the alleged onset date of disability was before January 1, 1954. As the States completed the necessary preparations and their capacity to handle a volume load increased, additional States asked to take the total workload of disability cases. By the end of 1956, two-thirds of the States were taking the total backlog. The remaining States have since modified their agreements to take all cases, some as recently as May 1959, so that about 80 percent of all disability cases now go to the States. Beginning soon, it is expected that State agencies will handle virtually all applications requiring a determination of disability. The Bureau will continue to process foreign claims and those of career railroad workers (see p. 48 of this Fact Book for details on coverage of railroad workers under the disability provisions), and, in the interest of expediting processing, cases which do not require a determination of the issue of disability, e.g., applicants who do not meet the insured status requirements or who do not submit any medical evidence.

EXPERIENCE UNDER THE 1954 AMENDMENTS

Within 2 years after enactment of the disability "freeze" provisions, approximately one-half million applications for the "freeze" were received by the Bureau. Priority was given to those cases involving the possibility of immediate benefit increases. About 100,000 cases resulted in such increases to disabled workers (already 65 and receiving retirement benefits) and their dependents or to survivors.

Although, as indicated above, the disability "freeze" provision did not become operative until July 1, 1955, the first "freeze" applications

were actually taken as early as January 1955 and the first disability determinations were made in the Bureau in March 1955. Most State agencies were able to establish an organization for handling "freeze" cases by the end of 1955; however, only a few achieved full operation in that year. In the first year of operation, the States took jurisdiction over only 1 out of 4 cases (about 60,000) requiring a disability determination and processed to final action just under 17,000 cases. Thus, it became necessary for the Bureau to process the major portion of the initial load. While some agencies, mostly States with large loads, continued to have difficulty during 1956 in recruiting and training staff as fast as the workload developed, others reached the point of effectiveness that permitted the acceptance of all backlog cases. In the second year of operation under the "freeze" program about one-half of the cases requiring a determination of disability were handled by the States.

By the end of 1956 a disability determination had been made on three-fourths of the applications received in the first 2 years of operation. A total of 130,000 cases were pending in the Bureau and in the State agencies.

EXPERIENCE UNDER THE 1956 AMENDMENTS

The administration of the disability "freeze" provisions was still evolving when the 1956 amendments were enacted. These significant amendments providing for cash disability benefits, as expected, more than doubled the volume of work experienced under the "freeze" program. In the first year of operation under these amendments the Bureau received about 450,000 new applications. These included applications for childhood disability benefits. In addition, more than 110,000 disabled workers over age 50, already in "freeze" status, became immediately eligible for cash benefits and in many of these it was necessary before beginning payment to verify the continuation of the applicant's disability.

When the 1956 amendments became law, there was also being experienced the initial impact of requests for reconsiderations and appeals from applicants who were denied the "freeze," and of investigations of the continuing eligibility of disabled persons for whom a determination of disability had previously been allowed. These various types of cases comprised about 20 percent of the total disability workload in 1957. With the enactment of the cash benefit provision, there was a further increase in requests for reconsiderations and hearings (see Part VI, of this Fact Book for details on experience with reconsideration and hearings cases).

With the expanded program, a new round of recruitment and training activities was carried out by the Bureau and State agencies. There was also the need for developing additional operating methods and management controls to handle an increased volume of cases and to insure that disability applicants would be promptly referred for vocational rehabilitation services.

Despite a continuing lag in some States in the recruitment of sufficient qualified staff to cope with increased workloads, the disability staff in the States almost tripled in the period between September 1956 and September 1957. Most States had to overcome the problem of achieving full productivity with new personnel and with policies and procedures—Bureau as well as State—that required continuous refinement in the light of experience.

The volume of the expanded workload resulted in above-normal pending loads and processing time in the first year of operation under the 1956 amendments. The volume of cases received by State agencies in 1957 (the first year of operation under the 1956 amendments) tripled the State agency workload.

At the end of October 1957 the total pending load (all types of disability cases) was 216,000. The State agency pending load was more than 100,000 cases. While the operating situation in many States was almost current, others had a backlog representing as much as 4 or 5 months' work. The agencies' capacity to handle volume loads, which was already increased by better trained staff, was supplemented by a variety of measures, depending on the individual operating situation. These included overtime, processing shortcuts, temporary transfer of personnel from other jobs, and assistance from Bureau district offices. Finally, by modification of the agreements between the States and the Bureau, backlog cases in 21 agencies were transferred to the Bureau for determination of disability. These actions, together with similar measures adopted by the Bureau, including overtime, resulted in a substantial reduction in pending loads by the end of the year.

By the end of March 1958 the disability workload of initial applications had been reduced appreciably, with pending loads close to normal. However, while the initial loads had been reduced, the increase in the reconsideration and hearing area was just building up. (See Part VI of the Fact Book.)

EXPERIENCE UNDER THE 1958 AMENDMENTS

When the 1958 amendments were enacted, the pending load of initial disability cases was approaching normal levels, and the total backlog of all types of disability cases was roughly 150,000. From October 1, 1958, the effective date for filing applications under the new amendments, through May 1959, there was an acceleration of applications, and the total initial applications for disability benefits, excluding applications for dependent's benefits, amounted to 300,000 for that period. The impact of initial claims under the amendments, together with the increase in reconsideration and appeals cases and in cases involving investigation of continuing eligibility, resulted in a substantial increase in the workload.

As in 1954 and 1956, it was necessary to recruit and train additional staff and otherwise to take the administrative action necessary to cope with the increased loads. As a whole, with a going organization and the experience gained under the previous amendments, this process was smoother than in the previous periods. State agencies, with jurisdiction for about three-fourths of the estimated total load, generally had less difficulty in recruiting additional staff than in previous years. The disability staff in the States increased from 850 full-time persons, at the time the 1958 amendments were enacted, to 1,100 by the end of May 1959, about four times the size of the staff on duty in 1956. This full-time professional and clerical staff is augmented by the part-time services of approximately 200 medical consultants, as well as the part-time services of regular agency medical staff engaged in securing evidence beyond that initially submitted, especially medical consultative examinations.

After the initial impact of the amendment load, the receipt of new disability claims leveled off and has been relatively stable. At the end of 1958, about 180,000 disability cases (124,000 initial cases) were pending in the Bureau and State agencies. By May 31, 1959, the total pending load had been reduced to about 161,000 cases (121,000 initial cases).

PROCESSING TIME FOR DISABILITY CASES

The problems inherent in developing evidence of the nature and extent of each applicant's disability and in evaluating the effect of his impairment upon his ability to engage in substantial gainful activity, make the process of determining disability more time consuming than the handling of regular old-age or survivors insurance claims. From the beginning of the disability operation, the Bureau has been concerned with the length of time it has taken to process disability claims and action has been and is being taken to speed up case processing at all points in the disability process.

The Bureau states that since the latter part of 1957, the median time for processing a new disability claim has been cut in half. If the medical documentation is complete and does not require supplementation after receipt by the State, many cases can now be processed in about 2½ months from the date of receipt of the application. The Bureau declares that recent changes in their procedures and refinements in State agency operating methods are resulting in still further reductions in total processing time. Some individual cases that involve special problems of medical evidence will, of course, continue to take longer than the normal.

One of the principal causes of processing lags is the time required to arrange for and secure reports on medical consultative examinations. In some States, delays are still encountered because of problems such as shortage of examining physicians in certain specialties and geographical areas, and difficulties in arranging for timely examinations and securing reports from the examining physicians. However, the Bureau states that progress has been made in overcoming these problems and many States have revised procedures and adopted shortcuts to expedite the purchase of consultative examinations. Continuing efforts are being directed to securing further improvements in this stage of case processing in all State agencies. (See pp. 124-125 for State agency processing time.)

DEVELOPMENT OF EVIDENCE ADDITIONAL TO THAT INITIALLY SUBMITTED

For each disability application, medical and other evidence concerning the applicant's disability must be gathered from available sources in order to determine whether the individual is under a disability. When additional evidence is necessary to make a sound determination and to properly document the file, further development is undertaken, usually by the State agency. This additional evidence is secured from available sources having knowledge of the applicant's condition and by the purchase of independent consultative examination, usually from specialists in or near the locality in which the applicant resides.

The purchase of independent examinations was approached conservatively by the Bureau and State agencies in the early days and expanded on the basis of experience. Under present law and policy ⁴ State agencies may have the applicant examined at trust fund expense when the evidence submitted by or on behalf of the claimant in connection with the initial claim spells out a reasonable likelihood of the existence of disability but it is determined that additional medical evidence is necessary for a sound determination; or in connection with a reconsideration, hearing, or litigation when additional medical evidence is considered necessary to provide a proper basis for the decision at the pending stage (which decision may be affirmation or reversal of the previous decision); or where the individual is currently on the disability rolls and there is a question whether such disability has ceased.

In addition to legal and policy questions that have had to be resolved for the State agencies, the principal problems in establishing a sound base for the examination process have been in orienting the medical profession to this process. The practices of State agencies in procuring independent examinations have involved questions of doctor-patient relationship and other matters of intimate concern to State medical societies and to individual practitioners. With the passage of time these concerns have been met by extensive consultation of the Bureau at the national level with medical organizations and with its Medical Advisory Committee (see Part VII of this Fact Book for details on this committee) and by similar consultation of State agencies with their State counterparts.

Since the beginning of the disability program, the State development rate has remained fairly stable; about 4 out of 10 of all cases processed by State agencies have required the development of some additional evidence. Over time, however, the proportion of cases has increased in which the additional medical evidence secured has been through the purchase of a consultative examination. In fiscal year 1956, medical consultative examinations were purchased for slightly under 1 percent of the total determinations processed by State agencies and the Bureau; and in fiscal 1958 for 13.2 percent. In the January-March 1959 quarter, medical consultative examinations were purchased for 17.6 percent of the total determinations processed. The rate of purchase for initial cases in that quarter was 16.4 percent and for reconsideration and hearing cases 29.4 percent.

TECHNIQUES FOR REVIEW AND CONTROL OF ADMINISTRATION IN THE DISABILITY OPERATION

From the beginning of the disability program, the achievement of uniform understanding and effective communication at all points in a widely dispersed operation has presented a problem. The need to accomplish uniformity of results has increased the need for intensive training and effective use of all media of communication.

Furthermore, each State agency, although performing a Federal disability operation, must operate within the framework of its State laws, organization, and administrative practices. Accordingly, the Bureau developed management policies, procedures, and guides to

⁴ See pt. V of this "Fact Book," "Outline of Disability Claims Process and Rehabilitation Referral."

permit some adaptation to meet State needs. In the area of management, the Bureau has also provided continuing guidelines on effective methods of operation based on the best experience in various State agencies.

The evaluation of disability operating experience, which has been a continuous process since the beginning of the program, is accomplished by various methods. Liaison is maintained with State agencies through regular visits of the Bureau's regional representatives to secure agreement on staffing, budgets, and procedures, and resolve day-to-day problems. In addition, a periodic on-the-scene review of disability operations is made in each State by representatives of the Bureau's central and regional offices to appraise the effectiveness of the operation as a whole, to identify problem areas, and to negotiate changes to improve operations.

Conferences of Bureau and State agency technical and management personnel are held periodically to evaluate operating experience, to isolate problem areas requiring further study or administrative action, and to promote a continuing analysis of internal processes to effect improvements, especially those which will bring about reduction in processing time consistent with sound determinations. The continuing analysis of regular and special operating reports also serves to point up backlogs or bottlenecks in operations which require attention.

FINANCIAL ASPECTS OF DISABILITY OPERATIONS IN STATE AGENCIES

Under section 221(e) of the Social Security Act, the costs that the States incur in making disability determinations are paid from appropriations made by Congress for the administrative expenses of the old-age, survivors, and disability insurance program (charged to the trust funds). On the basis of State agency budget estimates the Bureau advances money to the States. (In two small agencies, payment is made by reimbursement.) Any unexpended balance of these advances existing at the end of the budget period is used to finance costs in succeeding budget periods.

The Bureau prescribes fiscal standards governing the expenditure of Federal funds. Existing State practices for handling Federal funds and the State's choice of a depository for funds are usually acceptable to the Bureau. Funds must be identifiable, however, on the State's records. Accounting records and reports and supporting documents permit verification by Federal fiscal audit and by the Bureau in its administrative review.

The Bureau works closely with the State agencies in the preparation of their budget estimates. The agencies submit budgets, item by item, for specific objects of expenditure such as personnel, equipment, and medical examination costs. Their expenditures are not subject, however, to control on a line-item basis. State agencies must keep within the limitation of the total funds advanced for any period on the basis of an approved budget, although they may request and justify an increase for any period.

Expenditures of the State agencies for all phases of disability operations in the States give another indication of the growth of the program. In fiscal 1956, the first full year of disability operations in the States, the total expenditures were about \$1,500,000. For the fiscal

year 1959, total expenditures are expected to reach \$10 million (April-June quarter estimated). In the period starting with the last quarter of 1955 and ending with March 31, 1959, the cumulative total expenditure approximated \$22 million. These expenditures included the cost of additional medical evidence purchased by the States which increased from about \$18,000 (roughly 1 percent of the total) to close to \$2 million (28 percent) in the first three quarters of fiscal 1959. (See pp. 117-122 for State agency staffing and costs.)

The Department's Division of Grants-in-Aid Audits has completed the audits of expenditures of all the State agencies for fiscal years 1955 and 1956 (audits for fiscal 1957 have not yet been completed for all agencies). The questioned items of expenditure in the audits of fiscal 1955 and 1956 represented only about 2 percent of the total expenditures in the two periods covered by the audits. All of the questioned items were satisfactorily resolved.

PART V

OUTLINE OF DISABILITY CLAIMS PROCESS AND REHABILITATION REFERRAL

FILING APPLICATION IN BUREAU OF OLD-AGE AND SURVIVORS INSURANCE DISTRICT OFFICE

Applications for disability insurance benefits or for establishment of the disability "freeze" are filed with the local Bureau of Old-Age and Survivors Insurance district offices. As of June 1959, there were throughout the United States and in Hawaii and Puerto Rico 584 such district offices, as well as 34 resident stations and 3,650 other contact points where periodic service by a district office representative is maintained on a scheduled basis. The district office representative furnishes information about the eligibility requirements for benefits which include, in addition to disability, the insured status requirements, age, relationship, dependency, and so forth.

If the individual finds that he did not work long enough in covered employment to meet the insured status requirements or if he learns that his impairment is not of long enough duration or less severe than it would have to be for him to qualify, he might decide not to file. If he decides to apply, a staff member of the district office helps him complete his application and secure necessary proofs. At the same time, the person's earnings records are requested from the Bureau's Division of Accounting Operations in Baltimore.

DISTRICT OFFICE ROLE IN OBTAINING MEDICAL EVIDENCE

Where the issue of disability is involved, the district office arranges to interview the claimant about his disability. In the course of the interview, the applicant is asked to supply information on the nature and extent of his impairment, the way it limits both his daily activities and his ability to work, the medical treatment he has received, his education and work experience, and other facts pertinent to the evaluation of his disability. He is advised about the requirement that he supply medical evidence to support his claim, and the sources from which such evidence may be obtained. He is given report forms for his doctor to complete. These forms are supplied for the convenience of the doctor, but the doctor need not use these forms. He may make his report on his own letterhead, by photocopy of his records, or in any way he wishes. He is asked to provide an adequate summary of the history, diagnosis, physical and clinical findings, treatment, response, and supporting clinical facts so that a reviewing physician may evaluate the severity of the condition and the limitations upon the applicant. Most applicants take the forms given them by the district office to their attending physicians, but if the doctor is in some other area the district office may help the applicant prepare a letter requesting a report. The doctor returns the forms directly to

the district office. Where some agency or organization has medical information about the applicant's impairment, the district office will also help the applicant prepare a request to the organization for a report, or it may make the request directly on his behalf.

The medical report form, used by applicants to request information from their physicians or other medical sources, was designed with the assistance of the Medical Advisory Committee (see Part VII for details on this committee) and was modeled after the standard forms used by most insurance companies. Some special forms have been developed for use in special situations such as requests for medical information from mental hospitals where the applicant is hospitalized for a chronic mental impairment, or from Veterans' Administration hospitals.

District offices follow up to see that all necessary forms and reports are received, and they examine medical reports for completeness and conformity to very broad criteria but do not review them to determine their adequacy for adjudication, since this is considered a function to be performed under medical supervision.

FORWARDING CLAIMS

Under the law, disability determinations are made by cooperating State agencies, generally State vocational rehabilitation agencies, under contracts with the Secretary of Health, Education, and Welfare. In some States, certain classes of cases were specifically excluded from the agreements in the beginning of operations, and in these cases as well as in all foreign claims, the determinations are made in the Bureau's central office. (During the first year of operation under the disability program, calendar year 1955, about 1 out of 4 disability applications was sent to a State agency; at the present time better than 4 out of 5 go to a State agency for a determination of disability.) When its action is complete, the district office forwards the disability case to the appropriate State agency, or the Bureau's central Division of Disability Operations in Baltimore, whichever has jurisdiction.

Other limited types of disability cases involving ineligibility are forwarded by the district office directly to the Baltimore Payment Center or the Division of Disability Operations, because they do not require a determination by a State agency. Included in this group are: (1) The applications of persons who are clearly ineligible because they do not meet the insured status requirements specified in the law; and (2) the cases of persons who fail to submit any evidence to support their allegations of disability.

RESPONSIBILITY OF STATE AGENCIES

In the State agency, the case is assigned to a special disability determination unit where the determinations are made within the framework of standards and guides of the Bureau of Old-Age and Survivors Insurance, by a team consisting of a physician and a nonmedical specialist, both skilled in disability evaluation. All the evidence the applicant has submitted is examined. The physician member of the team reviews the medical evidence to see whether the clinical facts adequately describe the onset and course of the applicant's condition, its severity, and the handicap that it imposes upon the applicant. In order to reach his decision, the reviewing physician must consider

whether the medical facts supplied on behalf of the applicant adequately—

- (a) Describe a medically determinable impairment and confirm the diagnosis;
- (b) Indicate the severity of the condition;
- (c) Fix the date when it reached that level of severity;
- (d) Establish the extent of functional limitation;
- (e) Describe the indicated treatment and the applicant's response to treatment; and
- (f) Indicate whether the medical condition can be removed or improved by treatment to the extent that it would no longer prevent the applicant from engaging in any substantial gainful activity.

If the medical evidence is inconclusive on any of the points listed above, the State agency reviewing physician may ask the applicant's physician for some additional facts. Where the circumstances of the case require it, the reviewing physician may authorize a special examination at Government expense. These examinations are almost always conducted by specialists in private practice who perform these special examinations by agreement with the State agency. The fees are fixed in accordance with the fees that are usually paid doctors for conducting such examinations in connection with the regular programs administered by the State agencies.

If the information in file about the applicant's experience, work, or education requires further investigation because of the circumstances of the case, the State agency requests the district office to get additional evidence, or it may arrange for an interview with the applicant or ask for additional evidence from other sources.

The nonmedical specialist on the team relates (1) the implications of the clinical facts, as interpreted to him by the reviewing physician; (2) the other facts of the case; (3) the policy questions involved in the case (e.g., substantial gainful activity, sheltered work, etc.); (4) the applicant's potentialities for employment; and so forth to the applicable standards and policies. Weighing all the evidence and in this setting, the nonmedical specialist and the physician, acting as a team, arrive at a decision. They prepare the determination of disability (or no disability), establish the onset date, summarize the evidence, and prepare the explanation of the adjudicative determination.

EXAMINATION OF STATE AGENCY DETERMINATION AND AUTHORIZATION OF PAYMENT

After the State agency has completed its determination, the file is forwarded to the Division of Disability Operations of the Bureau in Baltimore for completion of the adjudication process. Under the law, determinations of the State agencies that are unfavorable to the applicant cannot be revised by the Bureau. Even though the Bureau has authority to revise a State agency determination only to make it less favorable to the applicant, the evaluators in the central Division of Disability Operations review all cases for consistency and conformity and communicate with the State agency when there are questions as to whether an individual determination is correct. After review of both the disability and nondisability requirements, the Bureau sends written notice to the applicant of the decision in his case as to

entitlement or nonentitlement and of his right to reconsideration and appeal, and, where an award of disability benefits is in order, certifies the payment to the Disbursing Office of the Department of the Treasury.

DETERMINING CONTINUANCE OR CESSATION OF DISABILITY

An individual who has been determined to be under a disability is required to and is instructed to report events which affect his rights, such as taking a job, becoming self-employed, or medical improvement. In addition, the accounting operations of the Bureau detect earnings posted to the social security account of the individual if he returns to work. The Bureau also receives reports from the vocational rehabilitation agencies on all referred cases. Aside from the above, changes in the individual's status may be shown by a continuing eligibility investigation resulting from a followup routinely scheduled at the time the initial determination of disability was made in certain kinds of impairments.

Upon receipt of a notice that an allowed disability applicant is working, that his medical condition has improved, or where a scheduled medical reexamination or review date is reached, the individual is asked to complete a "continuing disability" report. When it appears on the basis of this report and other information that an issue exists which involves the possible cessation of disability (either for freeze or insurance benefits), the appropriate State agency is requested to review the materials, get such additional evidence as is necessary, and make a determination of cessation or continuance of disability. These determinations of State agencies, like their determinations on the initial disability applications, are reviewed for consistency and accuracy by the Division of Disability Operations in Baltimore. Here also, the statutory prohibition against making State determinations more favorable applies. The results of the determination are communicated to the person affected. He has the same rights of reconsideration, hearing, and appeal as are available on all initial applications.

DISABILITY FREEZE DETERMINATIONS FOR CAREER RAILROAD WORKERS

The Social Security Amendments of 1954, which provided for the disability freeze, specified that employment in the railroad industry would count in determining whether an individual is insured for a disability "freeze." This provision was put into the law because of the very close coordination of the railroad retirement and OASDI programs established by the 1951 railroad retirement legislation.¹

There are four general types of situations in which a "freeze" of old-age and survivors insurance benefit rights may have a bearing as

¹ The first coordination of the railroad retirement and old-age and survivors insurance programs was provided for in amendments to the Railroad Retirement Act approved by Congress in 1946. This coordination of programs was greatly extended by railroad retirement legislation enacted in 1951. Under present law, in retirement, disability, and survivors' cases in which the worker has less than 10 years of railroad service, the employment records are combined and the benefits are paid by the old-age, survivors, and disability insurance system. In survivors cases in which the worker had 10 or more years of railroad employment, records are combined and the benefits are usually paid by the system under which the employee last worked. In retirement or disability cases in which the worker has a total of 10 or more years of railroad employment, railroad retirement benefits are payable on the basis of the railroad employment alone. Old-age or disability insurance benefits may also be payable to the same worker on the basis of employment under the OASDI program.

to career railroad workers (i.e., workers who have at least 10 years of railroad employment).

(1) The worker may have (or later acquire) enough employment under OASDI to qualify for retirement or disability benefits under this program.

(2) Upon the worker's death, the railroad credits may be transferred to the OASDI program, and benefits will be paid to the survivors under the OASDI program, not the railroad retirement program.

(3) The Railroad Retirement Act guarantees the career railroad worker an amount not less than he would have received had his services been covered under OASDI. A "freeze" might affect the amount he would get under OASDI and thus this minimum.

(4) There is a financial interchange of funds between the railroad retirement account (the fund used to pay benefits under the railroad retirement program) and the social security trust funds, the purpose of which is to provide continuing financial adjustments between the two systems so that OASDI does not profit or lose by the existence of a separate railroad retirement system. Accordingly, it is necessary to establish a "freeze" for railroad workers even where there is no OASDI employment in order to determine the extent to which there should be adjustment between the two systems.²

Even though the rights of railroad workers could be affected by the "freeze," there was no provision in the 1954 amendments authorizing the Railroad Retirement Board to make determinations of disability with respect to such workers. The Railroad Retirement Board found this unacceptable since it felt that it was the agency which Congress established to deal with railroad workers and that railroad employees and employers naturally look to the Railroad Retirement Board on such matters. Also, the Board felt that it would be more efficient administratively for it to make the "freeze" determinations for career railroad workers, as the Board would have to make a disability determination in any event, for cash benefit purposes under the Railroad Retirement Act. In addition, the Board took the position there would be less chance of the disability "freeze" determination being inconsistent with its determination for cash benefit purposes if it made both determinations.

The Department of Health, Education, and Welfare did not agree with the Railroad Retirement Board's proposal that the Board make "freeze" determinations which would be binding on the Department of Health, Education, and Welfare for all over-10-year railroad workers. Its reasons for this view were as follows: (1) The proposal made by the Railroad Retirement Board was incompatible with the responsibility of the Department for the administration of the OASDI program; (2) public relations problems might arise if the Department could not treat railroad workers who had substantial employment covered under the social security law the same as all other workers covered by that law; (3) decisions of the Railroad Retirement Board

² As a part of the coordination of the railroad program and OASDI, the 1951 and 1956 amendments to the Railroad Retirement Act provided for cost adjustments between the two systems, the stated purpose of which was to put the social security trust funds in the position they would have been had railroad employment been covered under OASDI since 1937. The railroad retirement system pays to the trust funds the social security taxes that would have been paid on the basis of railroad payrolls and in return is reimbursed for the additional benefits (and administrative expenses) that would have been payable under the Social Security Act had the railroad employment been covered under that act.

would affect the amount of money transferred from the social security trust funds to the Railroad Retirement account under the financial interchange and yet the Department would have no voice in these decisions.

Several meetings were held between the staffs of the two agencies in an effort to reach an agreement. On July 24, 1958, an agreement on a compromise approach was reached. Under the agreed-upon approach, the Board would make "freeze" determinations for career railroad workers conclusive only for the purpose of determining benefit payments under the railroad retirement program, while the Department of Health, Education, and Welfare would continue to make disability "freeze" determinations for all social security benefit purposes and for purposes of the financial interchange provisions. This compromise proposal was put into effect by an amendment to S. 2020 which was approved on September 6, 1958 (Public Law 85-927).

The Railroad Retirement Board and the Social Security Administration have adopted the following procedures for effectuating the "freeze." Generally, a career railroad worker who is disabled will go to the Railroad Retirement Board's office rather than the Social Security Administration's office to file a claim. In such cases, the Board gathers the necessary medical evidence and makes a determination as to whether the worker is disabled for cash benefit purposes and for the disability "freeze" for railroad retirement purposes. Social Security Administration personnel working in the Railroad Retirement Board headquarters offices are usually able, on the basis of the evidence gathered by the Railroad Retirement Board, to make disability "freeze" determinations for social security purposes.

In a relatively small proportion of cases, career railroad workers come into the Social Security Administration district office before going to the Railroad Retirement Board's office. Usually, these are cases in which the worker is applying for an immediate disability insurance benefit under social security. In these cases, the Social Security Administration ordinarily goes ahead with its own development of the case, and copies of the medical evidence are sent to the Railroad Retirement Board for its use in later making its determination. However, where it appears that the Railroad Retirement Board is going to immediately make a determination for cash benefit purposes, the Social Security Administration will not take action until it receives from the Railroad Retirement Board copies of the medical evidence on which the Board based its determination for cash benefit purposes.

REFERRALS FOR REHABILITATION SERVICES AND ACCEPTANCE OF SUCH SERVICES BY CLAIMANTS

One of the objectives of the Congress in enacting the disability provisions was to promote the rehabilitation of applicants for disability benefits. Following this policy, procedures have been set up so that all persons coming to the attention of the Bureau under the disability provisions may be considered for vocational rehabilitation services. Every person applying for a determination of disability whose application is sent to a State agency has his file screened in the State's disability determination unit under criteria provided by the vocational

rehabilitation agency, to assess his potential eligibility for vocational rehabilitation services. If from this initial screening it appears that it may be feasible for him to receive vocational rehabilitation services, copies of pertinent medical and nonmedical evidence are referred for counselors' action in the vocational rehabilitation agency. Whenever the application is not sent to a State agency, procedures have been developed for the Bureau to send State rehabilitation agencies copies of materials which would be useful in rehabilitation consideration. In addition, persons who inquire about the disability provision but who do not file applications, are also referred to State vocational rehabilitation agencies for consideration.

In order to insure that individuals receiving disability cash benefits would not defeat the rehabilitation objectives of the disability program to restore their capacity for gainful work, section 222(b) of the Social Security Act provides for withholding of such benefits for any month in which the beneficiary refuses, without good cause, to accept available rehabilitation services under a State vocational rehabilitation program. Where an offer of rehabilitation services is made and refused, or where the disabled beneficiary fails to respond to inquiries from the vocational rehabilitation agency, a report is submitted to the Bureau of Old-Age and Survivors Insurance for investigation, and any necessary action.

Another, more positive, incentive to rehabilitation of disabled beneficiaries is the provision of section 222(c) of the act under which a disabled beneficiary may engage in work activity, under a State vocational rehabilitation program, for up to 12 months without loss of disability benefits. With the assurance that there will be no loss of benefits during a period in which the disabled beneficiary is testing out his capacity to work, despite his disability, the acceptance of vocational rehabilitation services and the willingness to try out new work situations is encouraged.

Another incentive to attempts by disabled beneficiaries to test their ability to work, where State vocational rehabilitation agency assistance is not needed, is provided by the Bureau's policy not to terminate benefits in all cases upon notice of return to work. A period, not to exceed 3 months, is allowed for the individual, where there is question of his ability to hold down a job, to try out his capacity for substantial work. Under this provision, such a disabled individual is encouraged to make the attempt by the assurance benefits will not be interrupted if within a short period of time he finds himself unable to keep working. However, if the individual's situation is such that it is clear he has regained his capacity to work, his benefits are of course terminated.

PART VI

ADMINISTRATIVE APPEALS AND COURT CASES

If an individual is dissatisfied with the decision in his case, he has the right under the law to have a hearing, and if still dissatisfied after exhausting his administrative remedies, to obtain judicial review in the Federal courts (42 U.S.C. 421(d); 405 (b), (c) (7), (g), and (h)). In addition, the Social Security Administration has provided by regulation that a dissatisfied person may before requesting a hearing have his case reconsidered by the Bureau of Old-Age and Survivors Insurance (20 CFR 403.707ff). The administration of these provisions is described below.

RECONSIDERATION

When an initial decision is made on a person's application for benefits, or on a request for revision of an earnings record, or on an application for establishment of a period of disability, the applicant is notified in writing of the decision, and of his right to reconsideration or hearing if requested within 6 months. If the person questions the decision, he is furnished a further explanation of the basis for the Bureau's findings. Where he is still dissatisfied and wishes to pursue the matter, he is advised to ask for a formal reconsideration of his case. A person may under the regulations request a hearing before a referee without first asking for reconsideration, but in actual practice this is not usually done. The Bureau encourages the claimant to seek reconsideration on the premise that the relief sought may be obtained with less delay and inconvenience to the claimant, and with less cost to the program if the reconsideration action is favorable, and if unfavorable, a request for hearing may still be made. [On July 20, 1959, the Commissioner of Social Security decided that the formal regulations should be amended effective 60 days after publication in the Federal Register to make reconsideration a mandatory step in the administrative appeal process. Continuance of the new requirement will be dependent on experience.]

The reconsideration consists of a complete and independent reappraisal of the case, including not only the evidence already of record, but such new materials as can be made available. In disability cases where a determination for which a State agency is responsible is in issue, the case is referred back to the State agency for redetermination, by individuals other than those who made the original finding unless personnel is so limited as not to make this possible. In such cases of redetermination by the State agency, the decision is also carefully reexamined by a separate group of Bureau employees especially designated for this purpose. In reconsideration cases over which the Bureau has jurisdiction without State agency participation, the reappraisal and new decision is of course made in all cases by a separately designated group of Bureau employees.

When the reconsideration is completed, the Bureau notifies the person in writing of the conclusions reached and of his further right to a hearing which must be requested within 3 months of such notice, or within 6 months after notice of the initial decision, whichever is later.

HEARINGS

The hearings are conducted by regional referees, and are open to the parties, their attorneys or other appointed representatives, and to such other persons as the referee deems necessary and proper. The procedure at the hearing is informal, except that the testimony is under oath and is recorded verbatim by a reporter. The referee is required by regulation to inquire fully into the issues, to receive in evidence testimony of witnesses and relevant documents, to allow the appellant reasonable time to present arguments and examine witnesses, and otherwise conduct the proceedings in a manner as to afford the individual a fair hearing (20 CFR 403.709(g)). In some cases, the parties may waive their right to appear and present evidence and contentions at a hearing, in which event the referee may decide the case on the basis of the evidence of record. Where the referee feels that additional evidence is necessary for a proper determination, he may transmit the case to the appropriate State agency or to the Bureau for additional evidence. In disability cases, such additional evidence often involves the purchase of a consultative examination. The State agency may prepare a revised determination if warranted by the additional evidence. The procedure followed by the referee is consistent with the provisions of the Administrative Procedure Act (5 U.S.C. 1001).

Except where the case may be remanded to the Bureau for a revised decision (or, as is done rarely, certified to the Appeals Council for decision), the referee makes a decision in writing either affirming the prior decision, reversing it, or modifying it in whole or in part. A copy of the decision is mailed to the claimant with notice of his right to request review, within 60 days, of the referee's decision by the Appeals Council. Within 90 days of the referee's notice to the claimant, the Appeals Council may review the decision of the referee on its own motion.

APPEALS COUNCIL REVIEW

The Appeals Council carefully considers every case before it upon request for review or on its own motion. The council reviews a case on its own motion when the referee's decision would appear not in accord with the provisions of law or regulations.

Where the council is of the opinion that the referee's conclusion is correct in a case, it may deny the request for review on the basis that it would result in no advantage to the claimant, thereby permitting the referee's decision to stand as the Secretary's decision.

When the Appeals Council grants review, the claimant is given the opportunity to appear before the council in person or by attorney or other appointed representative, and to present additional evidence and a brief or statement on the merits of the case. The council then issues a decision in writing, reversing or affirming the referee. In some instances the council is of the opinion that development on particular points is warranted or a further hearing is justified. In this event, the case may be remanded to the referee for supplemental information or hearing and a revised or amended decision.

The appellant is notified in writing of the action of the Appeals Council, and is informed of his right to obtain further review by commencing a civil action within 60 days in a district court of the United States.

COURT REVIEW

The decision of the Appeals Council, or that of the referee if the Appeals Council has denied review, constitutes the final decision of the Secretary and exhausts the claimant's administrative remedies. After the Appeals Council has reviewed or declined to review the case, the claimant may commence a civil action in the Federal district court within the 60-day time limitation or within such additional time as may be granted on a showing of good cause. The court reviews the case on the record and cannot itself accept new evidence. The finding of the Secretary as to any fact, if supported by substantial evidence, is conclusive on the court. It may, however, remand the case to the Secretary for further hearing or the taking of additional evidence.

If dissatisfied with the decision of the district court, the claimant may carry his appeal further through regular appellate processes.

APPEALS EXPERIENCE

WORKLOAD—RECONSIDERATIONS AND HEARINGS

The number of requests for reconsideration and hearing has greatly increased with the expansion of the old-age and survivors insurance program and the addition of the disability provisions. To illustrate, in 1948 about 855,000 claims were filed and there were 5,114 requests for reconsideration, and 1,500 requests for hearing; in 1958 over 3¼ million claims were received and requests for reconsideration reached 92,664, while hearing requests totaled 23,259. Of the reconsideration requests in 1958, 46,218 (50 percent) involved the determination of disability; over 70 percent of the hearings requests in 1958 (16,561) were on the issue of disability.¹ This experience seems to indicate that the conditions imposed by the definition of disability are not as readily understood and accepted as are the conditions involving age, family relationship, and other more objective requirements of the old-age and survivors provisions of the act.

Since the law permitted persons whose disabilities began as far back as the last quarter of 1941 to qualify for disability benefits and for the disability freeze, the first years of operation under the disability program witnessed, as expected, peakloads of such applications, particularly for the cash benefits provided by the 1956 amendments. Workload data for the past few years reflect the impact of this initial backlog. By the end of 1958, in the first 4 years of operation under the disability program, well over a million determinations had been made on applications for disability benefits and disability freeze. As the Bureau and the State agencies stepped up disposition of disability cases to cope with this peakload of applications, the number of requests for reconsideration started growing, reaching a high of 27,300 in the second quarter of 1958. Similarly, as emergency measures and expansion of facilities increased the output of reconsideration actions to cope with the mounting backlog of such cases, the number of hearing requests began to grow. At the present time, increasingly successful efforts to handle the accumulated volume of hearing cases are reflected in the rise of requests for review by the Appeals Council and in civil actions being brought before the Federal courts.

¹ See Table A: Workload data—Reconsiderations and hearings, for complete data.

The magnitude of the workload in these areas is illustrated by the fact that more than eight times as many reconsideration cases and four times as many hearing cases were processed in the calendar year 1958 than were disposed of in 1955. About half of all the 1958 reconsideration actions and 70 percent of the hearing actions taken during that year were on disability cases. More recent data clearly reflect the fact that such measures as the increase in the permanent staff of referees and the special employment of Bureau personnel to act as temporary referees (see Part VII of this Fact Book for details) are rapidly reducing the workload problem and the delays resulting from the sudden increase of hearings requests in disability cases. The referees completed action on more than 4,800 requests for hearings on disability cases during the first 3 months of 1959 and on almost 3,700 requests for disability hearings during the 2 succeeding months of April and May.² This total of more than 8,500 disability hearing requests disposed of in the first 5 months of the year 1959 substantially exceeds the total number of hearing requests on disability cases acted upon during the 2-year period of 1956 and 1957; and it is expected that the number of actions taken during the first 6 months of 1959 will equal the output for the entire previous record year of 1958.

As of June 1, 1959, there were about 14,200 requests for hearings awaiting action by referees, of which about 10,800 were on disability cases. In terms of the time needed to process this workload, it is estimated that the pending hearing cases represent somewhat less than 6 months of work on the basis of production rates as of that date. Since full emergency measures are being continued, it is expected that with increased productive capacity the time to reach the pending cases will not actually be as long as 6 months. While the actual volume of these cases awaiting action is of course many times greater than the number pending as of the end of 1955, before the impact of the disability provisions, in terms of staff capacity the estimated time needed to process the hearing cases pending as of June 1, 1959, is less than the estimated 6.4 months of work on hand at the end of December 1955. While, for example, the volume of hearings pending as of the end of 1957 represented an estimated 11.1 months of work for the staff then available, the increase since then in the number of referees and in their productivity has served to reduce the pending load to the proportions existing before the impact of the disability provisions.

With respect to cases awaiting reconsideration, data as recent as that for hearing cases is not now available. As of April 1, 1959, there were 16,357 reconsideration cases (12,442 disability cases) pending Bureau action, representing in terms of staff as of that date an estimated 2.6 months of work. As with hearings cases this pending load in terms of estimated months of staff work is somewhat less than the 2.7 months of work estimated on hand as of the end of 1955. More recent data available only for disability actions show that disability reconsideration cases on hand had been reduced to 11,758 as of May 1, indicating an equivalent reduction in the overall number of cases awaiting reconsideration.

² Data on reconsiderations and hearings are issued on a quarterly basis; currently available data for April 1959 on disability reconsiderations and for April and May 1959 on both disability and on disability hearings cases are preliminary figures subject to possible minor adjustments.

REFEREE STAFFING IN RELATION TO DISABILITY PROGRAM

The impact of the disability program on the hearing process is illustrated by table E: Analysis of hearing requests, and by the chart following table E, showing the number of requests for hearing by month, August 1955 through May 1959, as well as the number of referees on duty during the same period. Referees on duty at stated dates during this period are also reflected in columnar form in table A: Workload Data—Reconsideration and Hearings—1947 through May 31, 1959.

It will be noted from the chart and table A that beginning with 1956, requests for hearing on disability cases began to rise sharply. Since July 1956, the number of disability hearing requests has consistently exceeded the number of hearing requests on old-age and survivor benefit cases. Even before the provision for cash disability benefits became effective, the total number of hearing requests had increased in a substantial amount, most of the increase being attributable to requests in disability "freeze" cases.

The 1956 amendments provided for disability insurance benefits payable for months beginning July 1957. The full impact on hearing cases of this new benefit category was not felt until the first few months of 1958. After September 1958, the number of requests for hearing decreased until March 1959, when there again was an increase, mainly attributable to the workload resulting from the 1958 amendments. The extent to which the hearing load is affected by the disability provisions can be illustrated by the fact that in July 1956, even before the cash benefit program, 53.6 percent of all requests for hearings were on disability "freeze" cases. In September 1958, this percentage reached a high point of 78.5 percent. In May 1959, it was 75 percent.

The number of referees on duty began to increase substantially in 1957, with a rise from 30 on duty at the end of 1956, to 75 by the end of 1957. The increase was needed to take care of the rising number of hearing cases, particularly because of the disability program. As the workload rose further in 1958, the referee staff was increased to 132 by the end of that year, and reached 145 on duty in February 1959, down to the present figure of 140 at the end of May, including 34 temporary referees. (See Part VII of this Fact Book.)

RESULTS OF ACTIONS TAKEN ON RECONSIDERATION

Of the more than 90,000 reconsideration actions taken on all types of cases in 1958, the Bureau reversed the prior decision in almost 37,000 cases, about 40 percent. In disability cases, the reversal rate was not quite as high, amounting to about 29 percent of the 47,000 disability reconsideration actions.³ An explanation for this lower reversal rate in disability cases is that an applicant disallowed under the more readily understood requirements of the old-age and survivors benefit provisions tends to a greater degree to request reconsideration only where he has new substantial evidence or other strong basis for disagreement. In the vast majority of the reversals in both disability and nondisability cases, additional evidence was considered which was not available initially.⁴

³ See Table B: Actions on Reconsideration for applicable data.

⁴ For 1958, there was additional evidence in 97 percent of the reversals on reconsideration; for disability cases alone, the figure was about 99 percent.

The more recent report as of March 31, 1959, shows somewhat higher rates of reversals, attributable probably to the fact that increasing public understanding of the disability provisions is serving to eliminate some unnecessary requests for reconsideration, and that increasing experience is resulting in better development of the facts needed to determine disability. Of the 18,910 reconsideration actions taken during the first 3 months of 1959, almost 9,000 or 47 percent were reversals. For disability cases alone, of 9,390 reconsideration actions, about 64 percent were affirmed and 36 percent reversed.

RESULTS OF ACTIONS TAKEN ON HEARING

In more than 10,000 (67.7 percent) of the 15,300 hearings requests acted on during 1958, the referee sustained the decision.⁵ In 1,114, or 7.3 percent, the referee reversed the original decision and found in favor of the claimant. In most of the remaining 25 percent, the case was remanded at the Bureau's request for a decision favorable to the claimant. This is done under a procedure whereby the Bureau examines cases before forwarding them for a requested hearing to see if, on the basis, for example, of any additional evidence submitted, or for any other reason, the prior unfavorable decision may be reversed.

As in the case of reconsiderations, and no doubt for similar reasons, the more recent figures for the first 3 months of 1959 show an increased rate of reversals by referees. Of the almost 7,000 actions taken in the first quarter of 1959, the Bureau's determination was sustained in 66 percent, reversed in 11.1 percent, while 12.4 percent were remanded at the Bureau's request and 10.2 percent were withdrawn, denied, or disposed of otherwise.

In disability cases, of the 10,726 requests for hearings acted on during 1958, the Bureau's decision was sustained in 8,111 (75.6 percent), and reversed in 441 (4.1 percent). The remaining 20.3 percent represented for the most part remands for favorable action at the Bureau's request. While not to the same extent as in reconsideration actions, additional evidence was involved in changes from the original decision in the majority of cases.⁶

Comparable figures for the first quarter of 1959 show 4,845 disability hearing actions, 69.5 percent of which sustained the decision, and 8.4 percent reversed. Of the remaining 22.1 percent, 12.9 percent were remanded at the Bureau's request for action favorable to the claimant.

REQUESTS FOR APPEALS COUNCIL REVIEW

Following the record number of referees' decisions in 1957 and 1958, requests for review by the Appeals Council of such decisions increased sharply beginning with 1958. During 1956, about 1,240 requests were received of which an estimated 620 were disability cases.⁷ In 1957, the requests totaled 1,780, with approximately 1,070 on disability issues. During 1958, 5,000 requests were received; an estimated 3,500 were disability cases. During the first 5 months of 1959 receipts were 3,543 (53 taken on the Council's own motion) which indicates the possibility of a 10,000 workload for 1959. The anticipated workload is based on experience showing that requests for review are filed in about 46 percent of referees' decisions unfavorable to claimant and a projected figure of 13,270 unfavorable referees' decisions for

⁵ See Table C: Actions on Hearings for further data.

⁶ For 1958, about 68 percent of all reversals, disability and nondisability, involved additional evidence.

⁷ The figures on disability cases are estimated figures, since the Appeals Council reports are on overall activities with no breakdown between disability and other cases.

the last 7 months of the year. The Appeals Council took action in over 3,700 cases in 1958, and 2,286 through May 1959. The number of cases on hand at the end of May 1959 was over 2,900, of which an estimated 2,000 (70 percent) were disability cases.

In about 80 percent of the requests disposed of, after careful review of the case, the Council formally denied the request, thereby permitting the referee's decision to stand as the final administrative decision in the case. Of the 2,286 cases which were reviewed by the Council during the first 5 months of 1959, 2,030 were thus disposed of without a formal decision by the Council. Forty-four were remanded to the referees for further action. Decisions were made by the Council in the remaining 212, the decision of the referee being affirmed in 140 cases and reversed in 72.

COURT ACTIONS

Civil actions have been filed in comparatively few cases under the old-age, survivors, and disability insurance program, the total being 791 from the beginning of the program in 1940 through March 31, 1959.⁸ As with administrative appeals, and for similar reasons, disability cases represent an increasing proportion of such cases, 120 (59 percent) of the 203 court actions brought during 1958 and 61 (79 percent) of the 77 actions brought in the first quarter of 1959, being on disability determinations. By contrast, only 169 actions were brought during the 2 years 1956-57, 50 of which (30 percent) were on the disability issue. As of March 31, 1959, there were 316 pending court cases, of which 189 (60 percent) were disability cases.

No decisions on litigated disability cases were made before 1957. During 1957, the district courts disposed of 64 actions under title II of the Social Security Act, 10 of which were disability cases. Of the 10 actions by the circuit courts of appeals, none involved disability. In 1958, 23 of the 65 dispositions of title II cases made by Federal district courts, and 1 of the 6 court of appeals decisions were on disability cases. During the first quarter of 1959, of 10 actions taken by the district courts, 8 were on disability.

Of the 75 decisions taken by the district courts from January 1, 1958, through March 31, 1959, 54 sustained the Department's decision, 13 reversed the decision in whole or in part, and 8 were dismissed because of action favorable to the plaintiff on remand at the Department's request. The comparable figures for the 31 disability decisions during the same period were 17 affirming the Department's decision, 6 reversed in whole or in part, and 8 dismissed because of action favorable to the plaintiff on remand. For the 10 court of appeals decisions, 7 affirmed the decision of the Department, including the 1 disability case, while the Department's decision was reversed in 3.

SUMMARIES OF COURT DECISIONS IN DISABILITY CASES

The following are summaries of the court decisions in disability cases, notices of which were received from the Department of Justice from the beginning of the disability program to May 15, 1959.

Section 1 contains short briefs of all disability cases in which the decision of the Department of Health, Education, and Welfare was

⁸ See Table D: Civil Court Actions for additional data.

affirmed by the court, and includes the one disability case decided by the court of appeals. Section 2 has somewhat more detailed summaries of the eight decisions on disability cases in which the Department's determination was reversed by the court. Section 3 lists disability cases which were dismissed by the U.S. district courts principally because of lack of jurisdiction, or in some instances by stipulation of the parties. Section 4 lists the disability cases which were dismissed after being remanded to the Department at the Department's request where a decision was rendered by the Department favorable to the plaintiff.

Where the case has been reported in the Federal Supplement, it is so cited. If it has not yet been officially reported, reference is made to the case as reported in the Unemployment Insurance Reporter published by Commerce Clearing House, Inc. (CCH). Otherwise, the name of the court, the civil case number, and the date judgment was entered are cited.

AFFIRMATIONS

(a) *Court of appeals.*—

Ussi v. Folsom (254 F. 2d 842 (2 Cir. 1958), affirming 157 F. Supp. 679 (D.C.N.D.N.Y. 1957)): The U.S. Court of Appeals for the Second Circuit affirmed, on the opinion below, the decision of the District Court for the Northern District of New York sustaining the Secretary's decision that the appellant did not qualify for a period of disability. The evidence showed that the appellant's impairment, although permanent, was only partial and that after he sustained a back injury while working at a metal plant he had thereafter worked for a number of years (and was still working) as a tailor. In the district court's opinion endorsed by the court of appeals it was held that the appellant's physical impairments did not measure up to the "stringent standards" required by the Social Security Act. The court of appeals also rejected the appellant's argument that he was not represented by counsel at the referee's hearing, holding that there is no requirement that this privilege be brought to the attention of an applicant.

(b) *District courts.*—

Wendt v. Folsom (CCH UIR, vol. 1A, Fed. par. 8305 (D.C.E.D. La. 1957)): The U.S. District Court for the Eastern District of Louisiana, in affirming the Secretary's decision disallowing the plaintiff's claim for a period of disability, held that "there is substantial evidence in the record, viewed as a whole, to support the Secretary's findings." The plaintiff, a clerical worker engaged in advertising and sales promotion work for 31 years, who had completed 3 years of high school, alleged that he had been retired by his last employer for disability on September 1, 1950, at age 56, and had been unable to work since. The evidence showed that he had a cerebral hemorrhage in April 1945, resulting in serious paralysis of the left arm and some loss of use of the left leg. However, he had worked regularly until his retirement, and as late as 1953 was able to ambulate without cane or crutches. Although he was found permanently and totally disabled by the Veterans' Administration, and by two insurance companies, the referee stated that their findings were not determinative of the disability issue under the provisions of the Social Security Act. The referee concluded that the evidence did not establish that the plaintiff had

been continuously unable to engage in any type of substantial gainful activity beginning at the time when he met the earnings requirements, i.e., prior to October 1, 1952, and that he had residual capacities which would permit him to do light clerical work.

Stamper v. Folsom (CCH UIR, vol. 1A, Fed. par. 8325 (D.C.E.D. Wash. 1957)): The U.S. District Court for the Eastern District of Washington applied the "substantial evidence" rule in affirming the Secretary's decision holding that the plaintiff was not entitled to a period of disability. The referee had found that the plaintiff, who in March 1952 was injured by being trapped between two railroad cars "has not been unable to engage in any substantial gainful activity by reason of a medically determinable physical condition or conditions since March 1952," and that the record would not support a finding that he "has residuals from his accident which are so severe as to prevent him despite his varied working experience, from engaging in any type of remunerative work." The referee also found that the plaintiff "has made no real attempt since his accident to obtain gainful work."

Fuller v. Folsom (155 F. Supp. 348 (D.C.W.D. Ark. 1957)): The U.S. District Court for the Western District of Arkansas affirmed the Secretary's decision that the plaintiff is not entitled to have the amount of his old-age insurance benefits increased by establishment of a period of disability. The plaintiff, whose education included 2 years of college, had been employed as comptroller and treasurer for a publishing company from which he retired for disability on his physician's advice in May 1946. He alleged that because of hypertension he was unable to work since that time. The referee had found that—

although the unpleasant symptoms related to hypertension may have made it advisable for the claimant to discontinue his usual work as comptroller and treasurer of the large corporation with its attendant pressures and responsibilities, from physical and clinical findings it is not shown that his overall ability was so severely impaired as to render him unable to do any type of substantial gainful work commensurate with his educational attainments, his training and experience.

The court concurred in this conclusion and added:

In passing, the court might say that if the question presented were whether the plaintiff was disabled from performing his work as comptroller and treasurer of the Encyclopaedia Britannica, or work of a similar nature or character, plaintiff's contentions might be well founded. But under the plain language of the statute, to establish a period of disability the plaintiff must show a medically determinable physical or mental condition which makes him unable to engage in any substantial gainful activity. The evidence of the plaintiff falls short in this regard, and, as above stated, the conclusions of the referee are correct.

Pehlert v. Folsom (CCH UIR, vol. 1A, Fed. par. 8360 (D.C.D. Ariz. 1957)): The U.S. District Court for the District of Arizona affirmed without opinion the Secretary's decision that the plaintiff was not entitled to the establishment of a period of disability. Medical reports showed that he had various ailments including bronchitis, bronchial asthma, and pulmonary emphysema and marked hypertension; that since 1948 when he allegedly became disabled he required constant medication, and had repeated hospitalizations. The plaintiff had a high school education and had worked as a personnel manager and in sales and service work before 1948. He was later employed part time as a salesman in 1949 and 1950, and for the years 1951, 1952, and the first half of 1953 was employed as a military

custodian at Arizona State College. From March 1956, he had been employed as an office worker for a trucking company until the position was terminated in May 1956 "because the employer was going to do the work himself." The referee had found that the plaintiff did "not have an impairment, or a combination of impairments, of such severity as to prevent him from engaging in *any* substantial gainful activity."

Remington v. Folsom (157 F. Supp. 473 (D.C.N.D.N.Y. 1957)): The U.S. District Court for the Northern District of New York affirmed the Secretary's decision that the plaintiff was not entitled to the establishment of a period of disability. The plaintiff, a shipping clerk with a ninth grade education, had suffered an injury to his spine in 1949 when he was 55 years old. The referee concluded that the condition was remediable without significant risk to the claimant's health and with reasonable expectation of a satisfactory result. The court commented that the referee's decision—

* * * reviews intelligently the legislative reports which indicate the extreme physical impairment that must be present to conclude definitely that the individual is precluded "from performing any substantial gainful work."

The court also stated:

The injury here is one to the back, most difficult, as any trial judge knows, to evaluate as to past, present, and future impairment.

However, the court said that it was important—

* * * that the specialists who examined him agreed that a spine fusion operation had good chance to remedy to a great extent the disability * * * [The] referee had the opportunity to observe and listen to the plaintiff at the hearing.

In the court's judgment—

* * * there is sufficient evidence in the record to support the referee's findings and conclusions as permissible even though as in all factual situations like this, particularly where medical diagnosis and opinion are present, reasonable argument could be made to infer and conclude the other way.

Crooks v. Folsom (156 F. Supp. 631 (D.C.E.D.N.Y. 1957)): The U.S. District Court for the Eastern District of New York affirmed the Secretary's decision that the plaintiff was not entitled to the establishment of a period of disability. The plaintiff had an eighth grade education supplemented by training in mechanical drafting and had had a variety of jobs mostly in the mechanical field. He alleged inability to work since 1949 when he was 59, because of an earlier amputation of his lower left leg, "astigmatism of brain," brain tumor, and laryngitis. As medical evidence, the statements of two doctors were submitted, which indicated that the claimant was treated for "chronic bronchitis" and "bronchiectasis" in 1946 and since July 1952. The Appeals Council (reversing the referee who had found "disability since April 1946 due to bronchiectasis") determined that there was an absence of clinical or laboratory findings to support a conclusion that because of a medically determinable physical or mental impairment, the plaintiff was unable to engage in any substantial gainful activity. In affirming the decision, the court held that—

there was a substantial basis in law for the inferences and conclusions reached by the Appeals Council in this record.

Hancock v. Folsom (CCH UIR, vol. 1A, Fed. par. 8355 (D.C.D.N.J. 1957)): The U.S. District Court for the District of New Jersey

affirmed the Secretary's decision that the plaintiff was not entitled to the establishment of a period of disability. The plaintiff, who alleged inability to work since July 1955 because of heart and respiratory ailments, had been employed before 1947 as a pipe coverer at a U.S. Navy yard, and thereafter worked as a watchman. The plaintiff contended that the fumes from the welding torches at the Navy yard were basically responsible for the later damage to his health. The medical evidence was in the words of the referee "extensive, voluminous, and conflicting," much of it in connection with a workmen's compensation claim, including among others a report of a neuropsychiatric examination. The referee had concluded that although the plaintiff had significant impairments, they were not sufficiently severe to preclude the claimant from working, and that it appeared from the evidence—

that claimant is suffering from a psychoneurosis * * * based on a hypochondriasis closely related to his tenacious and consistent purpose to prove that his illness since 1941 is due to metallic fume poisoning.

Dmytryshyn v. Folsom (CCH UIR, vol. 1A, Fed. par. 8390 (D.C.D. Mass. 1958)): The U.S. District Court for the District of Massachusetts affirmed without opinion the Secretary's decision disallowing a claim for establishment of a period of disability for at least 6 months before the plaintiff reached 65. The plaintiff, who became 65 in April 1952, alleged that he was disabled since January 1948 because of an injury to his leg and hip while employed as a welder and iron worker. The referee had found that he was not under a disability as defined by the law at the time the application for disability was filed in May 1955, since the evidence showed that the claimant recovered from his injury and returned to work in May 1950, and was more or less continuously employed thereafter.

Julian v. Folsom (160 F. Supp. 747 (D.C.S.D.N.Y. 1958)): The U.S. District Court for the Southern District of New York affirmed the Secretary's decision disallowing a claim for establishment of a period of disability where the evidence showed that plaintiff's disability, arthritis of the right knee, left hip, and lower lumbar spine, was not of such severity as to preclude him from engaging in any kind of substantial gainful work. In holding that "substantial evidence" supported the Appeals Council's findings, the court said, *inter alia*:

The medical reports produced by the plaintiff do not require that a contrary result be reached. The council was entitled to weigh and evaluate this testimony also in the light of its own experience and competence and against the background of his earnings record.

Drake v. Folsom (CCH UIR, vol. 1A, Fed. par. 8442 (D.C.W.D.S.C. 1958)): The U.S. District Court for the Western District of South Carolina affirmed the Secretary's decision denying a period of disability to plaintiff, who had been a "spinner" in a textile mill before becoming afflicted with arthritis. The Appeals Council had concluded that her condition was not so severe as to prevent her from doing work considering her education and experience. The court held there was substantial evidence in the record to support the finding of the Secretary.

Dupwich v. Folsom (CCH UIR, vol. 1A, Fed. par. 8433 (D.C.E.D. Okla. 1958)): The U.S. District Court for the Eastern District of Oklahoma held that there was substantial evidence to support the

Secretary's decision disallowing plaintiff's application for a period of disability. The plaintiff, a former miner, alleged he had been unable to work since September 1955 when he was about 61 years old, because of dizziness and blackout spells. The medical evidence showed several hospitalizations and treatment over a number of years (and in fact during pendency of plaintiff's appeal) for a variety of ailments including rheumatoid arthritis, hypertension, gastritis, umbilical hernia, a heart condition, prostate trouble, and 5 seizures of an epileptic nature all occurring "following considerable ingestion of alcohol and abstinence from food." The Appeals Council, after receiving additional evidence into the record had affirmed the referee's decision that the plaintiff was not entitled to a period of disability on the basis that the impairments were either remediable or not of such severity as to prevent the plaintiff from engaging in all types of substantial gainful activity. The Appeals Council stated that while he may not be able to continue in heavy labor as formerly, the plaintiff—does, however, have substantial residual capacities which would enable him to perform many types of sedentary work or other work requiring only moderate physical exertion.

Houriham v. Folsom (CCH UIR, vol. 1A, Fed. par 8452 (D.C.N.D. Ill. 1958)): The U.S. District Court for the Northern District of Illinois, in affirming the Secretary's decision denying plaintiff's application for a period of disability, held that the Secretary's findings were supported by substantial evidence. The plaintiff, who had attained age 65 in August 1952 and was receiving old-age insurance benefits, had worked until August 1951 as an accountant. He contended he was entitled to a period of disability beginning August 1951, because an impairment of his leg that had existed since 1903 hampered him in getting a job since that time. The court, quoting from the Congressional Reports, expressly held that under the definition of "disability" contained in the act it is not enough that an individual is simply unable to obtain employment and be unable to engage in his previous type of activity, but that he must be unable to engage in *any* substantial gainful activity.

Hallard v. Flemming (167 F. Supp. 205 (D.C.W.D. Ark. 1958)): The U.S. District Court for the Western District of Arkansas, in granting defendant's motion for summary judgment, found there was substantial evidence to support the referee's conclusion that the plaintiff could engage in substantial gainful work. The plaintiff had been a traveling salesman for many years prior to the alleged onset of a "cerebral accident" or stroke in 1950, and he claimed that his impairments, including anxiety state and hypertension prevented his ever returning to work. The court held that the plaintiff who, despite a limited amount of formal education, demonstrated over the years that he could earn sizable amounts annually as a salesman, may be held to be able to engage in substantial gainful activity, even though the work he could do would be of a sedentary nature for a few hours each day and be carried on from his own home.

Butler v. Folsom (167 F. Supp. 684 (D.C.W.D. Ark. 1958)): The U.S. District Court for the Western District of Arkansas affirmed the decision of the Secretary. Plaintiff had claimed disablement from arthritis in his knee and hip, and hardening of the arteries, but hospital records furnished by the Veterans' Administration showed that his impairments were not serious. The court agreed that these

records, reflecting thorough examinations, were properly held to be more persuasive and could be more effectively relied upon in determining whether or not the plaintiff was disabled than the reports filed by two doctors who without setting forth in detail their clinical findings concluded that the plaintiff was disabled and unable to engage in substantial gainful activity.

Townsley v. Flemming (CCH UIR, vol. 1A, Fed. par. 8524 (D.C.D. Ariz. 1959)): The U.S. District Court for the District of Arizona affirmed the decision rendered by the Appeals Council denying plaintiff a period of disability. The plaintiff, a restaurant cook with eighth grade education, alleged he became unable to work in September 1955 at age 59 because of shortness of breath, blackout spells, and pains in the head and chest. The evidence indicated that plaintiff had arthritis and emphysema to some degree, as well as a prostate condition for which surgery was recommended. The referee had held that claimant was disabled. The Appeals Council in reversing the referee on its own motion held that the medical evidence did not reasonably establish that during the period of insured status the claimant had either singly, or in combination, impairments of a degree of severity as to preclude him from engaging in any substantial gainful activity.

Graca v. Flemming (CCH UIR, vol. 1A, Fed. par. 8516 (D.C.N.D. Calif. 1959)): The U.S. District Court for the Northern District of California affirmed the Secretary's decision that the plaintiff was not entitled to a period of disability. The court based its decision not only on the failure of plaintiff to file her civil action within the 60 days allowed by section 205(g) of the Social Security Act, but also on the court's finding that plaintiff had received a full and fair hearing before the referee and that the referee's decision was supported by substantial evidence. The plaintiff was an ex-telephone operator who claimed that back pains prevented her from working since October 1953, when she was 56 years of age. The referee had held that the plaintiff had failed to establish that her impairments were of sufficient severity and extent to have continuously precluded her from engaging in any substantial gainful activity.

Miller v. Folsom (CCH UIR, vol. 1A, Fed. par. 8521 (D.C.S.D. Ind. 1959)): The U.S. District Court for the Southern District of Indiana affirmed without opinion the Secretary's decision denying the establishment of a period of disability for the plaintiff whose contention was that he suffered a disability by reason of a mine injury in 1949 to his leg, hip, spine, and pelvis, so that he was not able to return to work for approximately 2 years. Although after returning to work he received at least as much pay as he had before, he contended that his subsequent work in the mine for over 4 years until the mine closed permanently was in a job specially created for him by the mine operators.

Feser v. Folsom (U.S.D.C.S.D. Fla., Tampa Div., No. 3462-Civ-T, February 16, 1959): The U.S. District Court for the Southern District of Florida affirmed a referee's decision denying plaintiff a period of disability. The plaintiff, a former budget supervisor for Cities Service Co., had claimed inability to work because of neurasthenia. The evidence of record, which included a consultative neuropsychiatric examination indicated that plaintiff's symptoms were largely psychosomatic, and that while he was at the time suffering from a chronic severe depressive reaction, "it would seem there is a good chance of

rehabilitation and alleviation or at least modification of his symptoms through adequate treatment." On the basis of the evidence, the referee had concluded that the plaintiff had failed to establish a physical or mental impairment or impairments of such severity as to have continuously prevented him from engaging in any substantial gainful activity.

Kirkland v. Flemming (CCH UIR, vol. 1A, Fed. par. 8522 (D.C.W.D. Pa. 1959)): The U.S. District Court for the Western District of Pennsylvania affirmed the Secretary's decision that the plaintiff was not entitled to a period of disability. The plaintiff, a former steel-mill worker, had received serious injuries, including a fractured hip, in an automobile accident in June 1954 when he was 39 years old. The court concluded that the medical reports failed to establish the plaintiff was unable to engage in any substantial gainful activity, and noted that from the testimony of the plaintiff himself it appeared he had presently "some gainful employment requiring considerable activity on his part and that he is able to engage in other types of gainful employment for which he is fitted."

James v. Flemming (U.S.D.C.W.D. Pa., Civil No. 16445, January 15, 1959): The U.S. District Court for the Western District of Pennsylvania affirmed the Secretary's decision that plaintiff was not entitled to a period of disability. The court held that on the record the—

plaintiff has not sustained the burden of establishing a "medically determinable physical or mental impairment" within the meaning of section 216(i) of the Social Security Act.

The plaintiff, a mine foreman whose schooling consisted of completion of the third grade and some correspondence courses, alleged he could not work since July 1952 because of inability to walk or lift objects. His principal impairment appeared to be arthritic changes of the spine. The referee concluded that while there was evidence of an arthritic condition, his impairments were not severe enough to prevent the plaintiff from engaging in light or nonstrenuous work.

Manners v. Flemming (U.S.D.C.M.D. Tenn., Nashville Div., Civil No. 2543, Apr. 22, 1959): The U.S. District Court for the Middle District of Tennessee affirmed the Secretary's denial of the plaintiff's application for a period of disability. The evidence showed that plaintiff had been unable to engage in his usual occupation involving heavy manual labor since 1948 because of a back injury. The referee noted a conclusion by one physician that the plaintiff "could not be rehabilitated 'to a wage earning status.'" There was no evidence, except for the statements of the plaintiff, that he was unable to engage in light manual or sedentary work. In affirming, the court held that the final decision of the Secretary was supported by substantial evidence.

Eberhagen v. Folsom (U.S.D.C.S.D. Fla., Tampa Div., Case No. 3335-Civ-T., Apr. 22, 1959): The U.S. District Court for the Southern District of Florida affirmed the decision of the referee that plaintiff was not entitled to a period of disability. The plaintiff, who had worked as a machinist and oiler, alleged inability to work since April 1953 when he was 54 years old, because of back pains, a nervous condition, and lack of strength resulting from a kidney operation. The evidence indicated that the plaintiff had been treated for tuberculosis of the kidneys some years before, but that since removal

of one kidney, the other was functioning properly. The referee concluded that the claimant was not under a disability of such severity as to prevent him from engaging in any substantial gainful activity.

Kohrs v. Flemming (U.S.D.C.D. Nebr., Civil No. 0718, Apr. 27, 1959): The U.S. District Court for the District of Nebraska in affirming the Secretary's decision denying a period of disability, held that the Secretary's findings were clearly supported by substantial evidence. The plaintiff, whose work experience had included some 20 years' employment as a practical nurse for a doctor, had injured her left arm and shoulder which, even with several operations, had left her with the loss of most of its function. The court stated:

The failure of plaintiff to obtain employment on account of the physical impairment must be distinguished from an inability to engage in "any substantial gainful activity" by reason of such impairment. What constitutes substantial gainful activity cannot be measured by the type of gainful activity which plaintiff did or may have engaged in prior to her disability. The mere fact that plaintiff is unable to do the kind of work that she has been accustomed to perform immediately prior to her injury does not establish the total and permanent character of her disability. To support a finding of total and permanent disability, the plaintiff must show a determined, though unsuccessful, effort to attempt substantially gainful employment which is reasonably suitable for one suffering from the claimed impairment. The fact that plaintiff would not be able to work without some pain or discomfort is not cause for considering her case as one of disability.

REVERSALS

Bostick v. Folsom (157 F. Supp. 108 (D.C.W.D. Ark. 1957)): The U.S. District Court for the Western District of Arkansas reversed the Secretary's decision which held that the plaintiff is not entitled to establishment of a period of disability. Plaintiff, who was born December 15, 1907, completed 3 years of college and business training. In July 1951 she terminated employment involving extensive travel for a fund-raising concern. She stated that loss of weight and strength due to food and drug allergies, with menopausal complications, prevented work activity.

Reports from her attending physician and a specialist in allergometry showed she had been suffering from allergic reactions to foods (gastrointestinal respiratory allergies), migraine headaches, anemia, and menopausal syndrome. Her diet was rigidly controlled. After examination in October 1955, her doctor stated that disability was total but not permanent. The claim was denied on the ground that claimant did not have a medically determinable physical or mental impairment which could be expected to be of long continued and indefinite duration, or that so seriously affected her overall ability to preclude her engaging continuously in any type of substantial gainful activity.

The court held that there was no substantial evidence to contradict the conclusion of plaintiff's physician that she was "totally disabled" and that the law did not require that the disability be permanent. The court stated that since plaintiff had been totally disabled for more than 5 years and her prognosis was "indeterminate" in that "the end was not in sight," her impairments must be considered of long continued and indefinite duration. The court concluded that the evidence established that plaintiff could not perform any kind of substantial work.

Arnold v. Folsom (U.S.D.C. Oreg., Civil Action No. 9197, February 5, 1958): The U.S. District Court for the District of Oregon reversed

the Secretary's disallowance of an application for a period of disability. The plaintiff was born in 1903 and completed high school. She worked for a number of years as an egg candler, poultry picker, and agricultural laborer. She stated that she sustained an industrial injury in October 1953 when struck in the back and shoulder by a falling crate. Because of resultant difficulty in lifting and stooping she was unable to continue working. The medical evidence showed that the applicant was suffering from sacroiliac strain and a possible slipped disk, an emotional disorder characterized by neurotic tendencies and other bodily complaints of minor significance in the clinical picture. The report of one of the doctors included a statement that the applicant was not able to do work of any kind. The Oregon State Industrial Accident Commission awarded permanent partial disability benefits due to functional limitation of the back and arms. Suit against the Oregon Commission resulted in a jury verdict that the claimant was permanently and totally disabled. The referee found that the applicant's medically determinable impairments were not shown to be sufficiently severe to prevent her from engaging in any form of substantial gainful activity.

The court in reversing stated that there was no evidence in the records to show that the plaintiff was physically able to engage in any gainful occupation other than a statement by a representative of the Bureau of Old-Age and Survivors Insurance who had interviewed plaintiff that he observed no limp or restricted back motion, and he did not believe her impairment sufficient to stop her from engaging in substantial gainful activity. The court concluded therefore that the defendant's findings and conclusions were not supported by any substantial evidence.

Dunn v. Folsom (166 F. Supp. 44 (D.C.W.D. Ark. 1958)): The U.S. District Court for the Western District of Arkansas reversed the referee's decision denying plaintiff a period of disability and disability benefits. The plaintiff had a fourth grade education, was employed as a boiler fireman, and in December 1952 at age 54, injured his right ankle. After his foot was placed in a cast, on the advice of his doctor, he returned to work. However, the employment to October 1953 was intermittent. Plaintiff refractured his ankle and later developed an infection in the knee and a traumatic arthritis of the ankle. There were three operations on the right leg following which there existed a loss of function and stability of the leg. One doctor stated that plaintiff was unable to work, while another doctor estimated the disability of the extremity to be 80 percent, and recommended immobilization of the knee joint to stabilize the joint and decrease pain. This apparently was not done. With his request for review of the referee's decision, plaintiff furnished another report from his physician which showed, in addition to the leg condition, a loss of sight in one eye. The physician commented that plaintiff was completely incapable of any ambulatory work and had no education for any other kind of work.

The denial of the application was based upon the conclusion that the plaintiff's impairment did not affect more than one extremity and in the absence of involvement of other physical impairments was insufficient to establish inability to engage in any substantial gainful activity.

The court, finding for the plaintiff, stated that although the referee referred to a lack of other physical impairments, the plaintiff's testimony established that he was partially deaf and completely blind in one eye. The court emphasized the lack of rehabilitation potential and plaintiff's inability to do the type of work for which he was qualified by his education, skill, and industrial experience. In interpreting "substantial gainful activity," the court stated that such work is any activity for which the person is reasonably qualified by education, training, or skill, and that the determinative factor is not how substantial the gain is, but how substantial the activity in which the person could gainfully engage.

Enkel v. Folsom (CCH UIR, vol. 1A, Fed. par. 8487 (D.C.D. Minn. 1958)): The U.S. District Court for the District of Minnesota reversed a referee's decision holding that plaintiff was not entitled to a period of disability.

Plaintiff had a seventh grade schooling and was employed for many years as a route salesman for a tea company. His last job was as a stock clerk with the Northwest Airlines. He alleged that he became unable to work in January 1944, at age 57, because of arthritis of the spine.

Medical evidence showed that plaintiff received injuries when he fell on his back on a cement floor. This accident aggravated a pre-existing condition of osteoarthritis of the spine. He complained of stiffness in his back with limitation of movement in the spine, head, and neck. According to the medical reports there was no involvement of the lower extremities and no limitation of motion. He could bend forward, but backward and side bending were markedly limited. The evidence did not show that the spine was in an unfavorable angle or that any deformity was present. Two doctors stated he was totally and permanently disabled. Another doctor upon close questioning at proceedings before a referee of the Minnesota Industrial Commission in 1946 stated that claimant probably could, to some extent, do house-to-house sales work. Another doctor stated that claimant was disabled "insofar as any real exertion is concerned." Still another doctor was of the opinion that the claimant was not totally disabled and that when he saw him in December 1944 he believed there were many types of lighter work, not involving a great deal of bending or heavy lifting, which the claimant could do. The referee found that plaintiff was not under a disability at any time.

The court, without opinion, held plaintiff entitled to the period of disability claimed.

Aaron v. Folsom (168 F. Supp. 291 (D.C.M.D. Ala. 1958)): The U.S. District Court for the Middle District of Alabama reversed the Secretary's decision that plaintiff was not disabled within the meaning of the law.

The plaintiff was born in 1895 and completed high school. His varied experience included activity in automobile and grocery businesses, a postmastership, and work as a traveling salesman. He discontinued employment in September 1953 because of multiple complaints, including heart, back, and foot trouble, arthritis, prostatitis, and spastic colon. He subsequently rejected several offers of employment because his doctors had told him that "if he wanted to live longer" he would have to stop working. A medical report showed fatigue on limited exercise, tenderness of spine, pain on flexion, and

palpable arteries. The doctor stated that the claimant was unemployable. Veterans' Administration report of examinations of May 1954 showed lumbar arthritis with 75 percent of normal forward and backward bending of the spine without muscular spasticity or joint disturbance, flat feet, chronic rhinitis, prostatitis amenable to therapy, generalized arteriosclerosis, arterial vessels thickened, pulse rapid, no pedal edema, electrocardiogram normal and respiratory system normal. Psychiatric examination revealed anxiety reaction without disorientation, memory defect, or other abnormality. Claimant was described as well developed and nourished. No psychiatric therapy was recommended. Neurological examination was essentially negative. The referee, after considering plaintiff's heart ailment had not become worse in the last 20 years and plaintiff's present ability to travel from place to place, concluded the impairments were not so severe as to render him unable to engage in any substantial gainful activity.

The court stated that evidence presented to the referee consisting of diagnoses together with the opinions of several physicians, lay testimony, and proof of disability payments by an insurance company were all favorable and supported the allegation of disability. The court felt that there was no substantial evidence which did not corroborate the plaintiff's case, and that the Veterans' Administration report—

cannot constitute the substantial evidence required to support the referee's findings in view of the fact that all the other evidence is to the contrary.

The court stated that even though the act is in strong language and the congressional history indicates a strict policy of application, it did not—

interpret the act to apply only to the totally helpless and bedridden nor to those at death's door.

Hill v. Flemming (169 F. Supp. 240 (D.C.W.D. Pa. 1958)): The U.S. District Court for the Western District of Pennsylvania reversed the Secretary's decision denying plaintiff a period of disability.

The plaintiff, born February 22, 1896, had a sixth grade schooling and was employed as a machine operator. On November 3, 1945, while pulling on a crane hoist, he fell down striking his back and shoulder. He was under the care of a specialist until May 1946 when he was told that he could return to light work. He returned to employment, was given heavy work and after 4 days was forced to quit. He claimed that he had three broken vertebrae, but submitted no medical evidence to back this up. The reporting doctors stated that claimant had a low back ailment arthritic in nature. Two of the doctors gave their opinions that the claimant was "unable to work."

A medical report from the University of Pittsburgh's Falk Medical Clinic stated:

This patient was studied January 1955 through March of that year. Routine laboratory studies were negative. Serology was negative. Electrocardiogram was within normal limits. Chest X-ray revealed minimal left ventricular enlargement, and lung fields were clear. X-ray of spine revealed minimal osteoarthritic involvement of the lumbar spine. At that time a recheck of this case in our rheumatology clinic reported as follows: No evidence of real musculoskeletal disease. Movements of joints peripheral and spinal were free. No atrophy, swelling, or deformity, no hamstring spasm. No disturbance of gait.

The referee concluded that the evidence did not show an impairment of sufficient severity as to prevent plaintiff from being able to engage in any substantial gainful work.

In its opinion the court characterized the Falk Clinic report as "secondhand hearsay evidence * * * made by the Librarian" (although it was based on reports made by the examining physician). The court stated that this evidence was too remote and not at all probative of the ultimate facts in issue and hence was not substantial evidence. The court concluded that—

in our opinion there was no substantial evidence to contradict the medical opinions that plaintiff was totally and permanently disabled; neither was there any affirmative evidence that he had or could have, in view of his limited education and physical condition, engaged in any substantial gainful employment.

Teeter v. Folsom (CCH UIR, vol. 1A, Fed. par. 8504 (D.C.N.D. Ind. 1958)): The U.S. District Court for the Northern District of Indiana reversed the Secretary's decision denying establishment of a period of disability:

The plaintiff, born July 5, 1889, stated that he became unable to engage in substantial work in May 1946; that from 1916 until that time he had worked for Swift & Co. doing sales promotion and that he traveled by automobile about 30,000 miles contacting retailers. He alleged that he was prevented from working because he "can't stand still for more than 10 minutes. Extreme tiredness causes migraine headaches." Reports from the Mayo Clinic showed that claimant—

presented himself in 1945 because of headaches which were of two types, one being a migraine headache and the other being a very severe form of tension headache. Studies in our section of neurology and psychiatry failed to reveal evidence suggesting organic disease within the central nervous system. It was the suggestion of neurologists and psychiatrists by whom plaintiff was seen that he should modify his program of living in order to more effectively control the element of tension. Apparently, this tension was a major factor owing to his program of work * * *.

Laboratory and X-ray studies at the time were reported as essentially normal or negative with the exception of some arthritis of the spine. The clinic recommended baking, massage, a lumbosacral belt and a firm bed. He was urged to reduce his activities and his traveling and to use telephone and letters instead. The Mayo Clinic again reported in April 1955 "the migraine was found to be essentially controlled." Plaintiff furnished reports from two physicians. One physician gave the opinion that the back pain was increased by walking, lifting, or riding in a car. He "believed that claimant should have been considered unable to engage in any substantial gainful occupation from 1946 until now." The other physician stated that for the past several months claimant had "shown a weakening resistance to a general physical collapse." Doubt was expressed that relief could be effected without a complete separation from his work.

In denying the application, it was held that there were no objective findings of an individual unable to do any work of any kind full or part time. The referee stated that applicant's retirement from work was far from proving that he was in such a condition that he was unable to engage in any other occupation at a decreased tempo.

In finding for the plaintiff, the court stated that the statutory definition of disability—

does not allow the referee to form his own medical conclusion in the role of an expert as to what does or does not constitute a physical or mental impairment of long-continued and indefinite duration. That is the province of physicians and other qualified medical experts.

The court also stated that the referee misconceived the proper criterion to be applied in that "a substantial gainful activity cannot be equated to any work of any kind, physical or mental, full or part time."

An appeal to the Court of Appeals for the Seventh Circuit is now pending.

Dean v. Folsom (U.S.D.C.E.D. Ky., Civil Action No. 419, Apr. 17, 1959): The U.S. District Court for the Eastern District of Kentucky reversed the Secretary's decision that plaintiff was not under a disability.

The claimant born September 8, 1904, had a seventh grade schooling and was employed as a laborer loading bricks. He stated that the employing company closed its business in September 1953, but he continued working until the bricks were loaded out of the yard and in December 1954 was laid off work. He claimed that he became unable to work on December 22, 1954, due to arthritis and an inability to lift any weight. In 1956, he was awarded disability benefits from his employer. Reports from a doctor and a chiropractor showed a disk degeneration and marked arthritic changes in lumbar spine, with flexion contracture of the left hip. The chiropractor advised claimant not to work; the physician stated that claimant was unable to do any appreciable amount of manual labor particularly anything that uses the back.

After the case was remanded for additional development, the Appeals Council concluded that prior to March 16, 1956, when the application was filed, claimant's impairments were limited to arthritis of the lumbosacral area which undoubtedly precluded his doing extensive manual labor, but that he could engage in occupations of sedentary or quasi-sedentary nature.

The court stated that claimant—

appeared to the referee to be in good health, but the referee made no physical examination and has no medical proof to sustain his conclusions that the testimony of the doctors and their clinical examinations and findings were incorrect.

The court also stated that—

to say that this plaintiff can engage in a substantial gainful occupation is to be unrealistic. The Congress in enacting this legislation did not intend that it should be impossible for a person to bring himself within its terms and have the benefits which prompted its enactment. The claimant is incapable of carrying on any occupation except that of manual labor and all manual labor requires the use of the back. To speculate that he might engage in some other method of making a living as a reason for denying the claim is to lay down a precedent that would utterly destroy the worthy purpose of this legislation.

The court said, however, that it—

recognizes that the question is not to be resolved by opinion evidence and that medical men ought not to be asked or state their conclusions on the whole case and on the ultimate issue to be decided.

(An appeal is being recommended to the Department of Justice.)

COURT DISMISSALS (OTHER THAN AFTER FAVORABLE DECISION ON REMAND TO DEPARTMENT)

The district courts have dismissed the following cases for jurisdictional reasons or at plaintiff's request (other than after a decision favorable to plaintiff after remand to the Department):

Affatati v. Folsom (U.S.D.C.E.D.N.Y., Civil Action No. 17546, June 17, 1957).

Bowie v. Folsom (U.S.D.C.N.D.Ala., southern division, Civil Action No. 8487, May 29, 1958).

Bucklin v. Folsom (U.S.D.C.E.D.Wash., southern division, Civil Action No. 1216, Aug. 21, 1958).

Bax v. Folsom (U.S.D.C.E.D.Mo., eastern division, Civil Action No. 57C532(2), Oct. 2, 1958).

Edens v. United States of America (U.S.D.C.N.D.Tex., Dallas division, Civil Action No. 7748, May 15, 1958).

Hurt v. Folsom (U.S.D.C.W.D.La., Civil Action No. 6949, Sept. 15, 1958).

Lynch v. Folsom (U.S.D.C.E.D.S.C., Florence division, Civil Action No. 5964, Aug. 23, 1957).

Kerivan v. Folsom (U.S.D.C.W.D.Wash., southern division, Civil Action No. 2220, Apr. 21, 1958).

Hubbell v. Folsom (U.S.D.C.W.D.Wash., Civil Action No. 2263, May 26, 1958).

Burgess v. Flemming (U.S.D.C.N.D.Ga., Civil Action No. 1088, Oct. 1, 1958).

Russolesi v. Dept. Health, Education, and Welfare (U.S.D.C.S.D. Calif., Civil Action No. 1100-58 HW, Dec. 3, 1958).

Aldredge v. Flemming (U.S.D.C.N.D.Ala., southern division, Civil Action No. 9149, Feb. 6, 1959).

Ware v. Flemming (U.S.D.C.N.D.Ala., Civil Action No. 9291S, Apr. 10, 1959).

Marold v. Folsom (U.S.D.C.N.D.Ala., southern division, Civil Action No. 9139, Apr. 3, 1959).

Sellers v. Folsom (U.S.D.C.N.D.Ala., Civil Action No. 877-J, Apr. 7, 1959).

Earl v. Flemming (U.S.D.C.W.D.Ky., Owensboro division, Civil Action No. 826, Apr. 3, 1959).

White v. Folsom (U.S.D.C.D.Mass., Civil Action No. 56-802-S, June 10, 1957).

Cunningham v. United States of America (U.S.D.C.W.D.Mo., southwestern division, Civil Action No. 1485, Feb. 18, 1959).

DECISIONS FAVORABLE TO PLAINTIFF RENDERED BY DEPARTMENT AFTER REMAND FROM DISTRICT COURT

The Department in the cases below rendered a decision favorable to the plaintiff after remand from the district court. The court action was then dismissed based on the stipulation of the parties.

Werner v. Folsom (U.S.D.C.W.D.Wash., southern division, Civil Action No. 2064; dismissed September 16, 1957).

Bevis v. Folsom (U.S.D.C.S.D.Calif., central division, Civil Action No. 863-57Y; dismissed December 3, 1958).

Wassil v. Folsom (U.S.D.C.W.D.Pa., Civil Action No. 15771; dismissed December 18, 1958).

Brock v. Folsom (U.S.D.C.W.D.Wash., northern division, Civil Action No. 4431; dismissed June 26, 1958).

O'Leary v. Folsom (U.S.D.C.D.Mass., Civil Action No. 57-1069W; dismissal filed February 18, 1959).

Clinton v. Folsom (U.S.D.C.E.D.Tex., Tyler division, Civil Action No. 2414; dismissed August 8, 1958).

Shyers v. Folsom (U.S.D.C.E.D.Ky., Catlettsburg division, Civil Action No. 424; dismissed August 8, 1958).

DeGraff v. Folsom (U.S.D.C.E.D.N.Y., Civil Action No. 18716; dismissal filed December 12, 1958).

In addition the Department rendered a favorable decision on the following case which is waiting court dismissal:

Garrett v. Flemming (U.S.D.C.W.D.S.C., Spartanburg division, Civil Action No. 2426).

CASES REMANDED ON COURT'S MOTION OR AT PLAINTIFF'S REQUEST
STILL PENDING BEFORE THE DEPARTMENT

1. REMAND ON COURT'S MOTION

Center v. Folsom (U.S.D.C.S.D.Calif., Civil Action No. 2124-SD-C, 3/31/59).

Gaughenbaugh v. Folsom (CCH UIR, Vol. 1A, Fed. Para. 8427 (D.C.Neb. 1958)).

Hamilton v. Flemming (U.S.D.C.S.D.Fla., Jacksonville Div., Civil Action No. 4089 Civ.-J, 6/12/59).

Jacobson v. Folsom (CCH UIR, Vol. 1A, Fed. Para. 8345 U.S.D.C.S.D.N.Y. 1957).

Kauffman v. Flemming (U.S.D.C., W.D.Pa., Civil Action No. 16755, 3/10/59).

Little v. Dept. Health, Education, and Welfare (CCH UIR Vol. 1A, Fed. Para. 8568 (D.C.S.D.Miss. 1959)).

Ragucci v. Folsom (U.S.D.C.Mass., Civil Action No. 58-757-W, 1/13/59).

Sharp v. Folsom (U.S.D.C.W.D.W.Va., Civil Action No. 2018, 8/7/58).

Scales v. Flemming (U.S.D.C.Mass., Civil Action No. 58-1180-W, 5/26/59).

Waldrop v. Flemming (U.S.D.C.N.D.Ala., Jasper Div., Civil Action No. 880, 5/22/59 (amended 7/27/59)).

2. REMANDED AT PLAINTIFF'S REQUEST

Bolas v. Folsom (U.S.D.C.Neb., Civil Action No. 0489, 3/10/58).

Chapman v. Flemming (U.S.D.C.W.D.Okla., Civil Action No. 8262, 5/20/59).

Clifton v. Flemming (U.S.D.C.N.D.Tex., Ft. Worth Div., Civil Action No. 3956, 1/23/59).

Sarich v. Flemming (U.S.D.C.M.D.Pa., Civil Action No. 6254, 8/3/59).

Wray v. Folsom (CCH UIR, Vol. 1A, Fed. Para. 8449 (D.C.W.D. Ark., 1958)).

TABLE A.—*Workload data—Reconsiderations and hearings, 1947 through May 31, 1959*
 [Based on records of Bureau of Old-Age and Survivors Insurance]

Period	Number received		Referees on duty as of end of period shown	Actions taken		Pending as of end of period				Period
	Reconsideration	Hearings		Reconsideration	Hearings	Reconsideration		Hearings		
						Number	Months of work ¹	Number	Months of work ¹	
A. All cases:										
May 1959-----	(²)	3 1, 375	140	(²)	3 2, 535	(²)	-----	3 14, 172	3 5. 7	May 1959.
April 1959-----	(²)	3 1, 838	142	(²)	3 2, 440	(²)	-----	3 15, 332	3 6. 3	April 1959.
Jan. 1, 1959, to Mar. 31, 1959.	20, 726	5, 800	142	18, 910	6, 692	16, 357	2. 6	15, 942	7. 1	Jan. 1, 1959, to Mar. 31, 1959.
1958-----	92, 664	23, 259	132	91, 534	15, 348	14, 541	2. 2	16, 834	10. 4	1958.
1957-----	64, 678	13, 926	75	58, 912	9, 244	14, 502	2. 6	9, 420	11. 1	1957.
1956-----	44, 610	8, 080	30	37, 823	4, 927	8, 736	2. 1	4, 738	10. 8	1956.
1955-----	13, 500	3, 799	25	11, 287	3, 801	3, 711	2. 7	1, 792	6. 4	1955.
1954-----	12, 829	4, 093	-----	12, 139	3, 669	1, 608	1. 7	1, 806	5. 7	1954.
1953-----	12, 526	3, 901	-----	11, 788	3, 143	1, 762	1. 7	1, 555	5. 3	1953.
1952-----	7, 716	2, 520	-----	7, 300	2, 265	1, 034	1. 7	795	3. 9	1952.
1951-----	6, 269	1, 726	-----	6, 022	1, 496	768	1. 6	540	3. 8	1951.
1950-----	6, 022	1, 484	-----	4, 945	1, 693	1, 075	3. 2	195	1. 6	1950.
1949-----	5, 998	1, 727	-----	5, 824	1, 769	988	2. 2	404	2. 7	1949.
1948-----	5, 114	1, 500	-----	4, 940	1, 444	814	2. 1	445	3. 6	1948.
1947-----	4, 645	1, 286	-----	4, 402	1, 176	641	1. 6	389	3. 7	1947.

B. Disability cases:

	(²)	³ 1, 010		(²)	³ 1, 855	(²)	³ 11, 758		³ 10, 780		May 1959.
May 1959.....					³ 1, 834		³ 11, 625				April 1959.
April 1959.....		³ 1, 316		³ 4, 436	4, 845		12, 442		11, 891		Jan. 1, 1959, to
Jan. 1, 1959, to Mar. 31, 1959.		4, 427		9, 390							Mar. 31, 1959.
1958.....	46, 218	16, 561		47, 294	10, 726		10, 636		12, 309		1958.
1957.....	32, 495	8, 551		27, 358	6, 158		11, 712		6, 474		1957.
1956.....	23, 579	5, 240		18, 978	1, 447		6, 575		4, 081		1956.
1955.....	2, 244	303		270	15		1, 974		288		1955.

¹ The "Months of work" are estimated figures based on current production rates of existing staff as of the end of the period in question (including time taken as a result of requests for additional evidence). It is expected that with increased staffing and productive capacity and reduction in the time needed for additional

evidence requests, the time taken to reach presently pending cases will be less than the figures cited.

² Not available.

³ Available data for April and May 1959 are preliminary figures subject to adjustment.

TABLE B.—*Actions on reconsideration, 1947 through Mar. 31, 1959*

Period	Total actions	Affirmations		Reversals	
		Number	Percent	Number	Percent
A. All cases:					
Jan. 1 to Mar. 31, 1959-----	18,910	9,965	52.7	8,945	47.3
1958-----	91,534	54,708	59.8	36,826	40.2
1957-----	58,912	32,044	54.3	26,868	45.6
1956-----	37,823	25,560	67.6	12,263	32.4
1955-----	11,287	7,205	63.8	4,082	36.2
1954-----	12,139	7,997	65.9	4,142	34.1
1953-----	11,788	7,503	63.6	4,285	36.4
1952-----	7,300	5,134	70.3	2,166	29.7
1951-----	6,022	4,529	75.2	1,493	24.8
1950-----	4,945	3,811	77.1	1,134	22.9
1949-----	5,824	4,497	77.2	1,327	22.8
1948-----	4,940	3,845	77.8	1,096	22.2
1947-----	4,402	3,238	73.6	1,164	26.4
B. Disability cases:					
Jan. 1 to Mar. 31, 1959-----	9,390	5,977	63.7	3,413	36.3
1958-----	47,294	33,514	70.9	13,780	29.1
1957-----	27,358	16,875	61.7	10,483	38.3
1956-----	18,978	16,001	84.3	2,977	15.7
1955-----	270	251	93.0	19	7.0

TABLE C.—Actions on hearings, 1947 through Mar. 31, 1959

Period	Number of actions	Sustained decision		Reversed decision		Remanded		Denied, withdrawn, etc.	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
A. All hearings:									
Jan. 1 to Mar. 31, 1959-----	6, 692	4, 435	66. 3	740	11. 1	833	12. 4	684	10. 2
1958-----	15, 348	10, 383	67. 7	1, 114	7. 3	2, 615	17. 0	1, 236	8. 0
1957-----	9, 244	4, 504	48. 7	673	7. 3	3, 555	38. 5	512	5. 5
1956-----	4, 927	3, 076	62. 4	774	15. 7	673	13. 7	404	8. 2
1955-----	3, 801	2, 220	58. 4	973	25. 6	269	7. 1	339	8. 9
1954-----	3, 669	2, 086	56. 9	1, 072	29. 2	219	6. 0	292	7. 9
1953-----	3, 143	1, 754	55. 8	1, 006	32. 0	164	5. 2	219	7. 0
1952-----	2, 265	1, 283	56. 6	691	30. 5	70	3. 1	221	9. 8
1951-----	1, 496	939	62. 8	388	25. 9	39	2. 6	130	8. 7
1950-----	1, 693	1, 129	66. 7	390	23. 0	40	2. 4	134	7. 9
1949-----	1, 769	1, 214	68. 6	388	21. 9	52	2. 9	115	6. 5
1948-----	1, 444	996	69. 0	268	18. 6	44	3. 0	136	9. 4
1947-----	1, 176	784	66. 7	262	22. 3	21	1. 8	109	9. 2
B. Disability hearings:									
Jan. 1 to Mar. 31, 1959-----	4, 845	3, 365	69. 5	407	8. 4	627	12. 9	446	9. 2
1958-----	10, 726	8, 111	75. 6	441	4. 1	1, 874	17. 5	300	2. 8
1957-----	6, 158	2, 906	47. 2	131	2. 1	3, 016	49. 0	105	1. 7
1956-----	1, 447	994	68. 7	28	1. 9	402	27. 8	23	1. 6
1955-----	15	0	0. 0	0	0. 0	11	73. 3	4	26. 7

TABLE E.—*Analysis of hearing requests, disability and all others, August 1955 to May 1959*

[Based on records of Bureau of Old-Age and Survivors Insurance]

	Receipts				Referees on duty
	Disability	Other than disability ¹	Total	Percent disability	
1955—August.....	23	144	167	13. 8	23
September.....	100	737	837	11. 9	23
October.....	49	260	309	15. 9	24
November.....	88	468	556	15. 8	25
December.....	43	203	246	17. 5	25
1956—January.....	69	127	196	35. 2	25
February.....	154	267	421	36. 6	25
March.....	237	436	673	35. 2	25
April.....	250	186	436	57. 3	25
May.....	309	232	541	57. 1	25
June.....	345	266	611	56. 5	25
July.....	290	111	401	72. 3	25
August.....	549	212	761	72. 1	25
September.....	547	213	760	72. 0	25
October.....	777	273	1, 050	74. 0	26
November.....	1, 001	311	1, 312	76. 3	26
December.....	712	206	918	77. 6	30
1957—January.....	846	546	1, 392	60. 8	30
February.....	737	475	1, 212	60. 8	36
March.....	723	456	1, 179	61. 3	38
April.....	651	329	980	66. 4	42
May.....	856	449	1, 305	65. 6	44
June.....	647	331	978	66. 2	55
July.....	805	701	1, 506	53. 5	70
August.....	685	558	1, 243	55. 1	72
September.....	576	441	1, 017	56. 6	74
October.....	665	362	1, 027	64. 8	74
November.....	779	404	1, 183	65. 8	74
December.....	581	323	904	64. 3	75
1958—January.....	1, 032	526	1, 558	66. 2	76
February.....	665	425	1, 090	61. 0	76
March.....	822	424	1, 246	66. 0	82
April.....	1, 432	513	1, 945	73. 6	82
May.....	1, 740	621	2, 361	73. 6	82
June.....	1, 627	595	2, 222	73. 2	81
July.....	1, 845	676	2, 521	73. 2	99
August.....	1, 639	600	2, 239	73. 2	100
September.....	1, 078	462	1, 540	70. 0	133
October.....	2, 413	925	3, 338	72. 3	133
November.....	1, 105	425	1, 530	72. 2	133
December.....	1, 163	506	1, 669	69. 7	132

See footnote at end of table, p. 80.

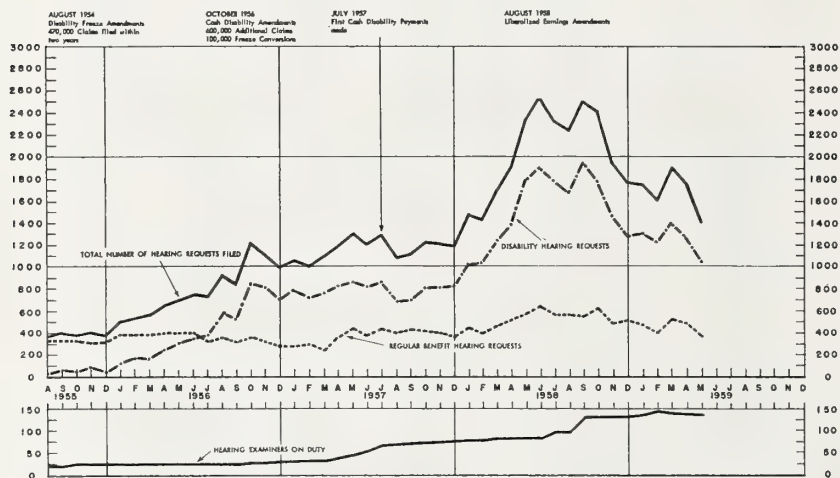
TABLE E.—Analysis of hearing requests, disability and all others, August 1955 to May 1959—Continued

[Based on records of Bureau of Old-Age and Survivors Insurance]

	Receipts				Referees on duty
	Disability	Other than disability ¹	Total	Percent disability	
1959—January-----	1, 637	510	2, 147	76. 2	137
February-----	1, 403	430	1, 833	76. 5	145
March-----	1, 387	433	1, 820	76. 2	142
April-----	1, 316	522	1, 838	71. 6	142
May-----	1, 010	365	1, 375	73. 5	140

¹ Receipts for other than disability cases are available by quarters only; monthly breakdowns in this column are therefore estimated.

CHART A.—HEARING REQUESTS AND EXAMINERS ON DUTY



PART VII

ORGANIZATIONAL STRUCTURE]FOR THE ADMINISTRATION OF THE DISABILITY PROGRAM

The Secretary of Health, Education, and Welfare has delegated to the Commissioner of Social Security with authority for redelegation the responsibility for the administration of the disability provisions of title II of the Social Security Act. The Bureau of Old-Age and Survivors Insurance by redelegation from the Commissioner of Social Security has the administrative responsibility for the program's operation, subject to the supervision of the Commissioner. The detailed responsibilities of the Bureau relative to the administration of the disability program are set forth in Part V of this Fact Book, "Outline of Disability Claims Process and Rehabilitation Referral."

In addition, the following perform roles in the administration of the disability program:

1. The Office of the Appeals Council (a part of the Office of the Commissioner of Social Security under authority delegated from the Secretary of Health, Education, and Welfare¹) through a staff of regional referees, is responsible for holding hearings and rendering decisions where the disability applicants are dissatisfied with the Bureau determinations on their applications and request a hearing; and through the Appeals Council is responsible for review of referees' decisions. These responsibilities are explained in Part VI of the Fact Book, "Administrative Appeals and Court Cases."

The Appeals Council, located in Washington, D.C., consists of 8 members and a chairman who is also the Director or administrative head of the Office of the Appeals Council. As of May 15, 1959, there were a total of 140 regional referees (106 permanent and 34 temporary) located throughout the United States and Puerto Rico for the purpose of holding hearings and making

¹ While the Office of the Appeals Council is part of the Office of the Commissioner of Social Security, it has been delegated direct authority relating to holding of hearings, the rendition of decisions, etc. The "Department Staff Manual on Organization," of the Department of Health, Education, and Welfare, sec. 8-000-20B, provides: "All duties, powers, and functions relating to the holding of hearings, the rendition of decisions, and the review of decisions in connection with the administrative appeals from determinations made under title II of the Social Security Act, as amended, and affecting benefits, lump sums, wage records or disability determinations, including the administration of oaths and affirmations, the issuance of subpoenas, the examination of witnesses, and the receipt of evidence, and all duties, powers, and functions relating to judicial review of decisions made upon appeal are assigned to the Office of Appeals Council in the Social Security Administration and shall be exercised by the Appeals Council, its members, and referees in accordance with applicable rules and regulations."

decisions on appeals under both the disability and nondisability provisions of title II of the Social Security Act.²

The permanent regional referees are appointed pursuant to the civil service qualification standards for hearing examiners subject to the Administrative Procedure Act, as set forth in the Civil Service Handbook X-118, "Qualification Standards Governing Non-Competitive Actions and Agency Recruiting" (series GS-935), and Examining Circular EC-17, issued October 21, 1947 (amended October 11, 1955). The standards as presently issued and interpreted by the Commission limit special qualifying experience (5 years minimum) in general to that of a trial lawyer, judge, or hearing officer, including judicial proceedings of courts of record and proceedings under the Administrative Procedure Act.

The 34 temporary referees are former employees of the Bureau of Old-Age and Survivors Insurance, who were appointed on a temporary basis without the need to meet the usual special qualifying experience, under temporary authority secured in connection with a supplemental appropriation act (Public Law 85-766 enacted Aug. 27, 1958). However, under the temporary authority, the qualifying experience required was admission to practice before a Federal or State court of record, and a minimum of 3 years' experience in the adjudication or consideration of claims for retirement, survivors, or disability benefits. This authority was due to expire December 31, 1959, but a provision is currently pending in connection with the Department's regular appropriation for fiscal 1960 to extend the provision through December 31, 1960. Justification for the special legislation and the special appointment of these temporary referees was on the basis of a need on an immediate basis for hearing officers with a present understanding of the old-age, survivors, and disability insurance provisions. Upon the expiration of the temporary authority, the individuals holding these temporary positions are to be returned to assignments in the Bureau. The Appeals Council also has attached to its staff a medical consultant whose function is to render medical advice to the Council members and referees, maintain liaison with contract medical consultants in the field, conduct and arrange for continuing medical training, prepare medical reference manuals and advise on medical policy and program.

2. State agencies under contract with the Bureau of Old-Age and Survivors Insurance, acting in behalf of the Secretary, are responsible for making determinations of disability on the basis of standards and guidelines provided by the Department. The legal and administrative framework for these contract relationships with State agencies, primarily State vocational rehabilitation agencies, is set forth in sections 221 and 222 of the Social Security Act. This relationship is essentially an agent-principal relationship.

The organizational patterns in the 56 contracting State agencies (56 contracting agencies in 52 jurisdictions including 49 States,

² On Apr. 16, 1959, the Secretary of Health, Education, and Welfare granted approval for a reorganization of the Office of the Appeals Council to establish three divisions within that Office and to establish regional hearing representatives to help direct field staff in the larger regional offices. Under this reorganization, which is now in process of being effected, the title of the office will be "Office of Hearings and Appeals," the chairman is designated "Director and Chairman," and referees designated "hearing examiners."

Hawaii, Puerto Rico, and District of Columbia; in the States of Delaware, Pennsylvania, South Carolina, and Wisconsin there are 2 contracting entities), vary widely. Nevertheless, there are certain characteristics which are fairly common.

(a) The contracting entity is generally a State rehabilitation agency which in turn is usually an organizational unit of the State department of education. In four States (Washington, New York, Oklahoma, and North Carolina) the contracting entity is the department administering public assistance programs.

(b) In each type of contracting agency, the responsibility for making determinations of disability has been added to other responsibilities of the head of the agency. In most agencies the rehabilitation of handicapped people is the major responsibility of the head of the agency.

(c) There is a person in each agency who is responsible to the head of the contracting agency for the supervision of the disability work. He is generally engaged in disability work on a full-time basis and may be assisted by one or more supervisory persons, and a staff of disability evaluation personnel. In nearly all agencies the staff handling this work is located in a separate section, or unit, of the agency. These full-time personnel may be supplemented by other agency technical and administrative personnel on a part-time basis.

(d) Each State agency has one or more full-time or part-time medical consultants on its staff working on the disability program. Frequently these are the medical consultants for the rehabilitation program.

(e) The determinations of disability are generally made at the headquarters establishment of the State agency, although in some States they are made at geographically separated points throughout the State, or both.

(f) To the extent that developmental work on claims is done in State agencies, the contact work with the applicants and with physicians may be performed by personnel engaged solely on disability work or by personnel also engaged in the agency's own program (e.g., local rehabilitation counselors).

3. The Bureau has made use of two advisory committees. One, a technical group, is known as the Medical Advisory Committee. This Medical Advisory Committee has served a most useful advisory function in the area of medical guides, relationships with the medical profession, medical report forms, etc. Beginning with the first meeting in February 1955, this 15-member Committee (see attachment 1 for list of members) has met 8 times.

The other advisory committee, currently known as the States' Council Committee on OASI Relationships, was established by its parent organization, the States' Vocational Rehabilitation Council (organization of all administrators of State vocational rehabilitation programs) to serve in an advisory capacity to itself and to the Bureau of Old-Age and Survivors Insurance. Beginning late 1954 this Committee has met 12 times. The

current membership of and the list of technical advisers to this Committee are shown in attachment 2. This Committee has served mainly as an administrative, as opposed to a technical, advisory group.

The contract relationships with the State agencies are set forth in the model agreement, a copy of which is shown as attachment 3. This agreement was developed by the Department with the advice and assistance of the States' Council Committee on OASI Relationships. This agreement served as a basis for negotiations with the contracting State agencies, and except for changes in jurisdiction over disability cases on the part of the agencies, is basically the same for each of the 56 contracting units. While the basic agreements originally entered into with the State agencies have remained in effect (substantially like the model agreement attached), there have been an average of about four modifications to each agreement. These modifications have been of four major types. First, expansion of the jurisdiction of State agencies to include cases where the alleged onset of disability occurred some years in the past. (Many agreements at first excluded such backlog cases from State jurisdiction because of initial limitations of State staff and facilities.) These modifications have now resulted in State agencies taking a progressively larger share of the total workload of disability applications. Second, minor and technical changes, generally minor adjustments in the jurisdiction of State agencies (both inclusions and exclusions), have been made on the basis of actual experience for the purpose of improving administrative efficiency. Third, "emergency modifications" transferring jurisdiction, for a limited period of time, over cases to the Secretary from State agencies encountering difficulty in coping with their workloads. Fourth, bringing the agreements into line with the provisions of the 1956 Social Security Amendments, namely to make provision for claims for benefits, to give effect to legal provisions relative to the definition of "blindness," and to recognize the creation of the disability insurance trust fund. These changes are documented by footnotes on the attached model agreement.

A listing of the contracting State agencies and officials with responsibility for disability administration is shown in attachment 4.

A listing of officials of the Department of Health, Education, and Welfare and constituent units with responsibility for disability administration is included as attachment 5.

ATTACHMENTS

1. List of members, Medical Advisory Committee
2. List of members and technical consultants, States' Council Committee on OASI Relationships
3. Model agreement with State agencies
4. Listing of State agencies and officials
5. Listing of officials of Department of Health, Education, and Welfare

MEDICAL ADVISORY COMMITTEE, BUREAU OF OLD-AGE AND SURVIVORS
INSURANCE, SOCIAL SECURITY ADMINISTRATION

J. Duffy Hancock, M.D. (Chairman), professor of surgery, University of Louisville School of Medicine, Louisville, Ky.

Miss Pearl Bierman, medical care consultant, American Public Welfare Association, Chicago, Ill.

Philip D. Bonnet, M.D., administrator, Massachusetts Memorial Hospitals, Boston, Mass.

Donald A. Covalt, M.D., associate director, Institute of Physical Medicine and Rehabilitation, New York University—Bellevue Medical Center, New York, N.Y.

Charles L. Farrell, M.D., president, Conference of Presidents and Other Officers of State Medical Associations; President-elect, the Rhode Island Medical Society, Pawtucket, R.I.

J. S. Felton, M.D., professor, Department of Preventive Medicine, University of California Medical School, Los Angeles, Calif.

Herman E. Hilleboe, M.D., commissioner, Department of Health, Albany, N.Y.

Lemuel C. McGee, M.D., medical director, Hercules Powder Co., Wilmington, Del.

Kenneth E. McIntyre, M.D., director, Metropolitan Hospital Clinics, Detroit, Mich.

William A. Pettit, M.D., State ophthalmologist for the California Department of Social Welfare, South Pasadena, Calif.

Leo Price, M.D., director, Union Health Center of the International Ladies' Garment Workers' Union, New York, N.Y.

William Harold Scoins, M.D., chief medical director, Lincoln National Life Insurance Co., Fort Wayne, Ind.

Carroll Shartle, Ph. D., chairman, Personnel Research Board, Ohio State University, Columbus, Ohio

Bryon Smith, executive director, Minneapolis Society for the Blind, Minneapolis, Minn.

David Wade, M.D., medical consultant, Division of Vocational Rehabilitation, Texas Education Agency, Austin, Tex.

STATES' COUNCIL COMMITTEE ON OASI RELATIONSHIPS, STATES'
VOCATIONAL REHABILITATION COUNCIL

The States' council committee is composed of the following members:
Claud M. Andrews, Division of Vocational Rehabilitation, 105 Knott Building, Tallahassee, Fla.

John A. Kubiak, Rehabilitation Division, 14 North Carroll Street, Madison 3, Wis.

R. C. Thompson, Division of Vocational Rehabilitation, 2 West Redwood Street, Baltimore 1, Md.

Seid W. Hendrix, Vocational Rehabilitation Division, 2655 Plank Road, Baton Rouge, La.

Joy O. Talley, Vocational Rehabilitation, 7th Floor, Jefferson Building, Jefferson City, Mo.

George F. Meyer, Executive Director, Commission for the Blind, 1100 Raymond Boulevard, Newark 2, N.J.

TECHNICAL CONSULTANTS TO THE COMMITTEE

Craig Mills, Division of Vocational Rehabilitation, 105 Knott Building, Tallahassee, Fla.

Roy Curtiss, Jr., State Department of Social Welfare, 143 Liberty Street, New York 6, N.Y.

Frederick W. Novis, State Department of Education, 33 Garden Street, Hartford, Conn.

Frank E. Hart, Bureau of Vocational Rehabilitation, 721 Capitol Avenue, Sacramento 14, Calif.

Committee members are directors of VR programs; the consultants to the committee are supervisors of State disability determination units.

MODEL AGREEMENT¹

(To carry out provisions of sec. 221 of the Social Security Act)

The Secretary of Health, Education, and Welfare, hereinafter referred to as the Secretary, and the State of _____, acting through (name of State agency), hereinafter referred to as the State agency, for the purpose of carrying out the provisions of section 221 of the Social Security Act (providing for the making of determinations of disability by State agencies), hereby agree to the following.

A. DEFINITIONS

For purposes of this agreement—

1. The term "disability" means inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration; or blindness. The term "blindness" means central visual acuity of 5/200 or less in the better eye with the use of correcting lens. An eye in which the visual field is reduced to five degrees or less concentric contraction shall be considered as having a central visual acuity of 5/200 or less.²

2. The term "determination of disability" includes one or more of the following determinations: (a) whether or not an individual is under a disability; (b) the date as of which the individual's disability began; and (c) the date as of which the individual's disability ceased.

¹ The modifications necessary to bring "Model Agreement" into line with provisions of Social Security Amendments of 1956 are indicated by footnotes along with other clarifying footnotes.

² After passage of Social Security Amendments of 1956 providing disability benefits, this statutory definition of blindness was restricted to "disability freeze" provisions.

3. The term "managing trustee" means the Federal official designated in the Social Security Act, and directed by such act to pay from the trust fund³ (established by sec. 201 thereof) such moneys as may be certified by the Secretary to him for payment.

4. The term "Secretary" means the Secretary of Health, Education, and Welfare or his delegate.

5. The term "necessary cost" shall include indirect as well as direct costs.

B. ADMINISTRATION

1. Upon request by the Secretary, the State agency will make determinations of disability with respect to individuals in the State⁴ who have applied to the Secretary for a disability determination under section 216⁵ of the Social Security Act, including cases in which such individuals have previously been determined to be under a disability for the purposes of such section of the act.

2. In making determinations of disability, the State agency will apply the term "disability" (as defined in pt. A of this agreement) in conformity with section 216(i)⁶ of the Social Security Act and such standards as may be promulgated by the Secretary.

3. The Secretary shall, if he finds necessary, promulgate standards, with respect to determinations of disability, to insure (a) the prompt and orderly processing of requests for such determinations, (b) equality in the treatment of individuals with the State, and (c) equality in the treatment of such individuals with the treatment accorded individuals in other States with which similar agreements have been entered into by the Secretary. If such standards are promulgated, the State agency will adopt such policies and procedures as may be necessary to conform to such standards so that the provisions of (a), (b), and, insofar as practicable, the provisions of (c) of this paragraph, are effectuated.

4. In any case in which the State agency is requested to make a determination of disability, the Secretary will furnish to the State agency any pertinent evidence he may have relative to the individual. The State agency will, in accordance with such standards as may be promulgated by the Secretary, secure from or through the individual or from other sources such additional medical or other evidence as the State agency considers necessary to enable it to make a determination of disability.

5. Each determination of disability will be certified by the State agency to the Secretary on such form or forms as may be provided by the Secretary. The State agency will also furnish the Secretary with the evidence considered in making its determination of disability in individual cases. Any such evidence forwarded to the Secretary by the State agency will be returned upon request. Except as provided in subsections (c) and (d) of section 221 of the Social Security Act, any determination of disability made by the State agency shall be the determination of the Secretary for the purposes of title II of the Social Security Act. The State agency shall not, however, be a party to nor assume any responsibility for defending the determination made by the Secretary pursuant to subsections (c), (d), and (g) of section 221 of the Social Security Act. Notification to the individual of the determination of disability will be made by the Secretary at the same time such individual is notified whether his insurance rights under title II of the Social Security Act are preserved on account of his disability.⁷

6. From time to time the Secretary will review such standards as he may issue pursuant to this agreement and, to the extent feasible, will consult with, and take into consideration the experience of, States or such group of States as he may consider representative, with which agreements have been entered into to carry out section 221, to determine the standards that are necessary and sufficient to effectuate the purposes of this agreement.

³ Pursuant to 1956 amendments word "fund" changed to "funds" because of creation of Federal Disability Insurance Trust Fund.

⁴ If the agreement is to cover not all individuals in the State, but only certain classes of individuals, the class or classes should be specified.

⁵ References to secs. 202(d) and 223 added to cover childhood disability benefits and regular disability benefits provided by 1956 amendments.

⁶ Reference to sec. 223 providing for disability benefits added to bring agreement into line with 1956 amendments.

⁷ Reference to benefit provisions of sec. 202(d) and sec. 223 added to reflect provisions of 1956 amendments.

C. PERSONNEL⁸

In carrying out this agreement, the State agency will follow its approved personnel standards in its plan under the Vocational Rehabilitation Act (29 U.S.C. sec. 31 et seq.). If there is no approved personnel standard for a particular position, the State agency will, in the selection, tenure of office, or compensation of any individual in such position, apply such standards as are consistent with the personnel standards in its plan under the Vocational Rehabilitation Act.

or

In carrying out this agreement, the State agency will follow the provisions of the merit system under which it operates.⁹ If there is no approved personnel standard for a particular position, the State agency will, in the selection, tenure of office, or compensation of any individual in such position, apply such standards as are consistent with the provisions of the merit system under which it operates.

or

In carrying out this agreement, the State agency will follow "Standards for a Merit System of Personnel Administration" issued by the Department of Health, Education, and Welfare, Social Security Administration, September 1, 1948, as amended.

D. ORGANIZATION

1. As may be agreed upon by the State agency and the Secretary, the State agency will provide such facilities, employ such qualified personnel, and provide such medical consultative services as are necessary to develop expeditiously evidence with respect to disability determinations. Such personnel shall be subject to the jurisdiction of the State agency.

2. The determination of disability based upon the evidence developed by such personnel shall be made by a medical consultant and by another individual or individuals qualified to interpret and evaluate medical reports relating to the physical or mental impairment (as referred to under the definition of "disability" in part A of this agreement) and to determine the capacity of the individual, with respect to whom a determination of disability is necessary, to engage in substantial gainful activity. The personnel utilized by the State agency to make determinations of disability shall be placed in such offices as may be agreed upon by the State agency and the Secretary.

3. The State agency will establish cooperative working relationships with other public agencies concerned with problems of the disabled and, insofar as practicable, utilize the services, facilities, and records of such agencies (a) to assist the State agency in the development of evidence with respect to and in the making of determinations of disability, and (b) to assure that the congressional policy promulgated in section 222 of the act (relating to the referral of disabled individuals for rehabilitation services) will be effectively carried out. Such public agencies may be reimbursed for such services, facilities or records furnished pursuant to subparagraph (a), and the State agency shall include such costs in the estimates or requests for reimbursement furnished pursuant to part G.

4. Under procedures established with the (agency of the State administering program for the blind), the State agency will utilize the services of such former agency to assist it in the development of evidence as to whether an individual is under a disability by reason of blindness and in the making of determinations of disability in such cases. The (agency of State administering program for the blind) shall be reimbursed by the State agency for its necessary cost in making determinations of disability pursuant to this provision and the State agency shall include such cost in the estimates or requests for reimbursement furnished pursuant to part G. The State agency will make such arrangements with the (agency of the State administering program for the blind) as may be necessary to conform to the provisions of part G.

⁸ Three alternatives are provided in this part. The first one will be used if the State agency administers a plan approved under the Vocational Rehabilitation Act; the second, if the State agency is some other agency and follows a merit system; the third, if such other State agency does not follow a merit system.

⁹ "Merit system" refers to the State's civil service or other comparable system relating, among other things, to the selection, tenure of office, and compensation of individuals employed by the State and operating under personnel standards established and maintained on a merit basis. If such system can be referred to by a State statutory citation, the statutory citation might be used.

E. MEDICAL EXAMINATIONS

In making arrangements for medical or other examinations and tests necessary to make determinations of disability, the State agency will pay the prevailing fees or costs for such examinations and tests, in accordance with the fee schedule in effect for purposes of the State program it administers.¹⁰

Where a particular examination or test is not included in an established fee schedule, the State agency will not bind itself to pay any fee or cost for such examination or test which is in excess of the highest rate paid by Federal or State agencies in the State for the same or similar type of services.

F. REPORTS AND RECORDS

The State agency will make such reports in such form and containing such information as the Secretary may require, and will comply with such provisions as the Secretary finds necessary to insure the correctness of such reports, including provisions made for the inspection and review of fiscal, statistical, and other records and the review of operations within the scope of this agreement.

G. FISCAL

1. The Secretary will provide funds, either in advance or by way of reimbursement, as may be mutually agreed upon, for the necessary cost to the State agency of making determinations of disability authorized by this agreement. Such funds will be paid periodically by the Managing Trustee to -----¹¹ upon certification by the Secretary, and will be used solely for such expenses. Where, for purposes of the State program it administers, the State agency utilizes any service or material purchased or contracted for by it pursuant to this agreement, the cost of such service or material shall, pursuant to standards issued by the Secretary, be prorated and only that part which is attributable to the making of disability determinations authorized by this agreement shall be considered a necessary cost for the purpose of this agreement.

2. The State agency will submit estimates of anticipated costs for such periods, at such times, and in such manner as may be requested by the Secretary. After considering all pertinent information, the Secretary will determine the amount of funds that are necessary for the State agency to administer its agreement under section 221 of the Social Security Act for a particular period and that are available to keep within the limits of Federal funds allocated to carry out the purposes of such section. The Secretary will notify the State agency of the amount which will be certified for payment to it for such period. The State agency will not incur or make expenditures for such period which will exceed the amount the Secretary certifies for such period unless in advance of making or incurring such expenditures the State agency obtains approval of the Secretary for such expenditures.

3. After the close of a period for which funds have been certified in advance to the State agency, the State agency will submit a certified report of its actual expenditures for such period in such manner and within such time as may be designated by the Secretary. After considering all the pertinent information, the Secretary will determine whether such expenditures were necessary in making determinations of disability authorized by this agreement under standards in effect at the time such expenditures were made or incurred. If, pursuant to such standards, the Secretary determines that any such expenditure was not necessary for such purpose, the Secretary shall so inform the State agency of tentative exceptions taken with full explanation of such tentative exceptions. The State agency will be given a reasonable length of time to justify such expenditures. If such expenditures cannot be justified by the State agency, the total amount of expenditures actually made and incurred in such period shall be reduced by any expenditures determined by the Secretary to be not necessary in making determinations of disability authorized by this agreement. The difference between the advance payment made to the State agency and the expenditures determined to be necessary for such period will be adjusted, within

¹⁰ This provision will be used only if the State program is operated under a plan which, pursuant to Federal statute, has the approval of the Secretary (e.g., a State vocational rehabilitation program, or a program under title XIV of the Social Security Act). If not, then the following provision will be used:

"In making such arrangements the State agency will pay the prevailing fees or costs for such examinations and tests in accordance with the fee schedule established by the agency of the State administering a plan under the Vocational Rehabilitation Act" (29 U.S.C., sec. 31 et seq.).

¹¹ There should be inserted here the appropriate State official who is authorized to act as custodian of the moneys paid by the Federal Government to the State to carry out this agreement. Indicate title of office, not the name of the incumbent.

the limits of available funds, either by appropriate increase or reduction in the amount certified for advance by the Secretary for subsequent period.

4. Where funds are to be paid to the State agency by way of reimbursement for expenditures made or incurred by the State agency in a particular period, the State agency will submit a certified report of such expenditures in such manner and within such time as may be designated by the Secretary. After considering all the pertinent information, the Secretary will determine whether such expenditures were necessary in making determinations of disability authorized by this agreement under standards in effect at the time such expenditures were made or incurred. If, pursuant to such standards, the Secretary determines that any such expenditures were not necessary for such purpose, the Secretary shall so inform the State agency of tentative exceptions taken with full explanation of such tentative exceptions. The State agency will be given a reasonable length of time to justify such expenditures. If such expenditures cannot be justified by the State agency the total amount of expenditures actually made and incurred in such period shall be reduced by any expenditures, determined by the Secretary to be not necessary in making determinations of disability authorized by this agreement. Where such total amount exceeds the amount that will be certified to the State agency as determined by the Secretary pursuant to paragraph 2, it shall be reduced as may be necessary in order to keep within the limits of Federal funds available to carry out the purposes of section 221 of the act. The amount so determined shall be certified by the Secretary to the Managing Trustee for payment to -----¹²

5. Any moneys paid to the State which are used for purposes not within the scope of this agreement shall be returned to the Treasury of the United States for deposit in the appropriate¹³ trust fund.

6. All estimates and reports of expenditures and other reports will be prepared in accordance with appropriate budgetary and accounting methods, and administrative practice as recommended by the Secretary and agreed to by the State agency. The State agency will furnish or make available such supplemental accounts, records, or other information as are required to substantiate any estimate, expenditure, or report, as requested by the Secretary or as may be necessary for auditing purposes or to verify that expenditures were made only for purposes authorized by this agreement.

7. The State agency will comply with such standards as the Secretary may promulgate with respect to the responsibility of, and the accountability by, the State agency for property purchased by it with funds certified by the Secretary to it under this agreement.

H. CONFIDENTIAL NATURE AND LIMITATIONS ON USE OF DISABILITY DETERMINATION INFORMATION AND RECORDS

In accordance with standards promulgated by the Secretary, the State agency will adopt policies and procedures to insure that information contained in its records and obtained from others in connection with carrying out its disability determination functions under this agreement will be used solely for the purpose of making determinations of disability. Such information shall be disclosed only as provided in section 1106 of the Social Security Act and regulations promulgated thereunder by the Secretary.

I. MODIFICATION OF AGREEMENT

This agreement may be modified at any time by mutual consent of the parties to the agreement.

J. TERMINATION BY STATE AGENCY

This agreement may be terminated by the State agency on ----- advance notice in writing to the Secretary, or without such advance notice if it certifies to the Secretary and, if requested by the Secretary, such certification is accompanied by an opinion of the attorney general of the State, that it is no longer legally able to comply substantially with any provision of this agreement.

¹² Insert here the name of appropriate State official as under footnote 11.

¹³ Word "appropriate" inserted to reflect creation of Federal disability insurance trust fund by 1956 amendments.

K. TERMINATION BY THE SECRETARY

The Secretary may terminate this agreement on ----- advance notice in writing to the State agency. He may terminate it without such notice if he finds that he is no longer legally able to comply substantially with any provision of this agreement and so notifies the State agency in writing, or after affording an opportunity for hearing to the State agency, he finds that the State agency is no longer legally able or has failed to comply substantially with any provision of this agreement. If, under this part of part J, this agreement is terminated, any funds paid to the State agency under part G of this agreement which have not been expended or encumbered in accordance with the terms of this agreement prior to the date as of which the agreement was terminated and any property purchased with funds paid to the State agency under part G of this agreement, shall be accounted for with due regard to the equities of the parties to such funds and property.

L. EFFECTIVE DATE

This agreement shall be effective as of -----

This agreement is entered into the ---- day of -----, 19--, by -----, Commissioner of Social Security, acting herein by virtue of authority vested in him by -----, Secretary of Health, Education, and Welfare and the State of -----, acting herein through (-----).

Name of State agency

Name of State agency

By (signed) -----
Secretary of Health, Education, and Welfare.

By (signed) -----
Commissioner of Social Security.

Listing of State agencies and officials with responsibility for disability administration

Alabama-----	Mr. O. F. Wise, Director, Division of Vocational Rehabilitation, 416 State Office Bldg., Montgomery, Ala.
Alaska-----	Mr. Ray Hruschka, Director, Office of Vocational Rehabilitation, Box 2568, Juneau, Alaska.
Arizona-----	Mr. M. W. Holdship, Director, Division of Vocational Rehabilitation, 1704 West Adams St., Phoenix, Ariz.
Arkansas-----	Mr. Don W. Russell, Director, Vocational Rehabilitation Service, 303 Education Bldg., Little Rock, Ark.
California-----	Mr. Andrew Marrin, Director, Vocational Rehabilitation Service, 721 Capital Ave., Sacramento, Calif.
Colorado-----	Mr. Warren Thompson, Executive Director, Department of Vocational Rehabilitation, 510 State Office Bldg., Denver, Colo.
Connecticut-----	Mr. James S. Peters II, Chief, Bureau of Vocational Rehabilitation, State Department of Education, 33 Garden St., Hartford, Conn.
Delaware—VR-----	Mr. John G. King, Director, Rehabilitation Division, 11 Concord Ave., Wilmington, Del.
Delaware—Blind-----	Dr. Francis J. Cummings, Executive Secretary, Delaware Commission for the Blind, 305-307 West 8th St., Wilmington, Del.
District of Columbia---	Mr. Norman W. Pierson, Director, Department of Vocational Rehabilitation, 819 9th St. NW., Washington, D.C.
Florida-----	Mr. Claud M. Andrews, Director, Division of Vocational Rehabilitation, 105 Knott Bldg., Tallahassee, Fla.
Georgia-----	Mr. A. P. Jarrell, Director, Division of Vocational Rehabilitation, 129 State Office Bldg., Atlanta, Ga.
Hawaii-----	Mr. Kuniiji Sagara, Director, Division of Vocational Rehabilitation, Box 2360, Honolulu, Hawaii.

Listing of State agencies and officials with responsibility for disability administration—Continued

Idaho.....	Mr. Milo T. Means, Director, Vocational Rehabilitation Service, 210 Eastman Bldg., Boise, Idaho.
Illinois.....	Mr. C. O. Cline, State Supervisor, Division of Vocational Rehabilitation, Room 400, State Office Bldg., Springfield, Ill.
Indiana.....	Mr. Ort L. Walter, Director, Division of Vocational Rehabilitation, 145 West Washington St., Indianapolis, Ind.
Iowa.....	Mr. Merrill E. Hunt, Director, Division of Vocational Rehabilitation, 415 Bankers Trust Bldg., Des Moines, Iowa.
Kansas.....	Mr. Norman G. Evans, State Supervisor, Vocational Rehabilitation Service, 11th Floor, State Office Bldg., Topeka, Kans.
Kentucky.....	Mr. Ben F. Coffman, Head, Bureau of Rehabilitation Services, State Office Bldg., High Street, Frankfort, Ky.
Louisiana.....	Mr. S. W. Hendrix, Director, Vocational Rehabilitation Division, 2655 Plank Rd., Baton Rouge, La.
Maine.....	Mr. Gray H. Curtis, Executive Director, Vocational Rehabilitation Division, 32 Winthrop St., Augusta, Maine.
Maryland.....	Mr. R. C. Thompson, State Director, Division of Vocational Rehabilitation, State Office Bldg., 301 West Preston St., Baltimore, Md.
Massachusetts.....	Mr. Francis A. Harding, Commissioner of Rehabilitation, Massachusetts Rehabilitation Commission, 37 Court Sq., Boston, Mass.
Michigan.....	Mr. Ralf A. Peckham, Assistant Superintendent for Vocational Rehabilitation, Office of Vocational Rehabilitation, 900 Bauche Bldg., Lansing, Mich.
Minnesota.....	Mr. August W. Gehrke, Assistant Commissioner for Rehabilitation and Special Education, Division of Vocational Rehabilitation, 517 Commerce Bldg., St. Paul, Minn.
Mississippi.....	Mr. Travis McCharen, Director, Division of Vocational Rehabilitation, 316 Woolfolk State Office Bldg., Post Office Box 1698, Jackson, Miss.
Missouri.....	Mr. Joy O. Talley, Director, Vocational Rehabilitation, 7th Floor, Jefferson Bldg., Jefferson City, Mo.
Montana.....	Mr. Leif Fredericks, State Director, Bureau of Vocational Rehabilitation, 508 Power Block, Helena, Mont.
Nebraska.....	Mr. Fred A. Novak, Assistant Commissioner for Rehabilitation Services, State Capitol Bldg., Lincoln, Nebr.
Nevada.....	Mr. William E. Shultz, State Director, Division of Vocational Rehabilitation, Capitol Annex, Carson City, Nev.
New Hampshire.....	Mr. Kenneth E. Shute, Director, Vocational Rehabilitation Division, Room 424, 18 School St., Concord, N.H.
New Jersey.....	Mrs. Carl Holderman, Director, Rehabilitation Commission, 38-40 South Clinton Ave., Post Office Box 845, Trenton, N.J.
New Mexico.....	Mr. Aud F. Darr, State Director, Division of Vocational Rehabilitation, 119 South Castille St., Santa Fe, N. Mex.
New York.....	Mr. Peter Kasius, Deputy Commissioner, State Department of Social Welfare, 270 Broadway, New York, N.Y.
North Carolina.....	Dr. Ellen Winston, Commissioner, State Board of Public Welfare, Raleigh, N.C.

Listing of State agencies and officials with responsibility for disability administration—Continued

North Dakota-----	Mr. Merle Kidder, Director, Division of Vocational Rehabilitation, Box BB, University Station, Grand Forks, N. Dak.
Ohio-----	Mr. Edward J. Moriarty, Director, Bureau of Vocational Rehabilitation, 79 East State St., Room 309, Columbus, Ohio.
Oklahoma-----	Mr. L. E. Rader, Director, Department of Public Welfare, Post Office Box 3161, State Capitol Station, Oklahoma City, Okla.
Oregon-----	Mr. Charles F. Feike, Director, Division of Vocational Rehabilitation, 509 State Office Bldg., 1178 Cheme-keta St. NE., Salem, Ore.
Pennsylvania—VR----	Mr. Charles L. Eby, Director, Bureau of Rehabilitation, Labor and Industry Bldg., 7th and Forster Sts., Harrisburg, Pa.
Pennsylvania—Blind---	Mr. Norman Yoder, Commissioner, State Council for the Blind, Department of Welfare, Health and Welfare Bldg., 7th and Forster Sts., Harrisburg, Pa.
Puerto Rico-----	Mr. Domingo Collazo, Director, Vocational Rehabilitation Division, Edificio Zequeira, Stop 34½, Hato Rey, P.R.
Rhode Island-----	Mr. George F. Moore, Jr., Chief, Division of Vocational Rehabilitation, 205 Benefit St., Providence, R.I.
South Carolina—VR---	Mr. P. G. Sherer, Director, Vocational Rehabilitation Department, 1015 Main St., Room 217, Columbia, S.C.
South Carolina—Blind-	Mr. J. M. Cherry, Chief, Division for the Blind, State Department of Public Welfare, Post Office Box 1108, Columbia, S.C.
South Dakota-----	Mr. C. L. Eskelson, Director, Division of Vocational Rehabilitation, Capitol Bldg., Pierre, S. Dak.
Tennessee-----	Mr. Earl Oldham, Director, Division of Vocational Rehabilitation, 1717 West End Bldg., Room 615, Nashville, Tenn.
Texas-----	Mr. J. J. Brown, Director, Vocational Rehabilitation Division, 1st Floor, Land Office Bldg., Austin, Tex.
Utah-----	Mr. L. B. Harmon, State Director, Vocational Rehabilitation Division, 400 Atlas Bldg., 36½ West 2d St., Salt Lake City,, Utah.
Vermont-----	Mr. Francis S. Irons, Director, Vocational Rehabilitation Division, 16 Langdon St., Montpelier, Vt.
Virginia-----	Mr. R. N. Anderson, Director, Vocational Rehabilitation, State Department of Education, Richmond, Va.
Washington-----	Mr. George C. Starlund, Director, Department of Public Assistance, Post Office Box 1162, Olympia, Wash.
West Virginia-----	Mr. F. Ray Power, Director, Vocational Rehabilitation Division, State Capitol Bldg., Room W-400, Charleston, W. Va.
Wisconsin—VR-----	Mr. John A. Kubiak, Chief, Rehabilitation Division, State Board of Vocational and Adult Education, 14 North Carroll St., Madison, Wis.
Wisconsin—Blind-----	Mr. Thomas J. Lucas, Director, Division of Public Assistance, State Department of Welfare, 311 State St., Madison, Wis.
Wyoming-----	Mrs. Mildred C. Cassidy, Division Director, Division of Vocational Rehabilitation, 123 State Capitol Bldg., Cheyenne, Wyo.

Listing of officials of Department of Health, Education, and Welfare with responsibility for disability administration

Department of Health, Education, and Welfare:

Secretary	Arthur S. Flemming.
Assistant Secretary (for Legislation)	Elliot L. Richardson.
General Counsel	Parke M. Banta.
Assistant General Counsel, Old-Age and Survivors Insurance Division.	Harold P. Packer.

Social Security Administration:

Commissioner of Social Security	William L. Mitchell.
Deputy Commissioner of Social Security	George K. Wyman.
Legislative reference officer	Charles E. Hawkins.
Chairman, Appeals Council	Joseph E. McElvain.
Chief Actuary	Robert J. Myers.

Bureau of Old-Age and Survivors Insurance:

Bureau Director	Victor Christgau.
Deputy Bureau Director	Robert M. Ball.
Assistant Director in Charge of Division of Claims Policy.	Ewell T. Bartlett.
Assistant Director in Charge of Division of Program Analysis.	Alvin M. David.
Assistant Director in Charge of Division of Disability Operations.	Arthur E. Hess.
Assistant Director in Charge of Division of Claims Control.	Richard E. Branham.
Assistant Director in Charge of Division of Field Operations.	Hugh F. McKenna.

Office of Vocational Rehabilitation: Director	Mary E. Switzer.
---	------------------

CHART B.—ORGANIZATION, SOCIAL SECURITY ADMINISTRATION

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social Security Administration

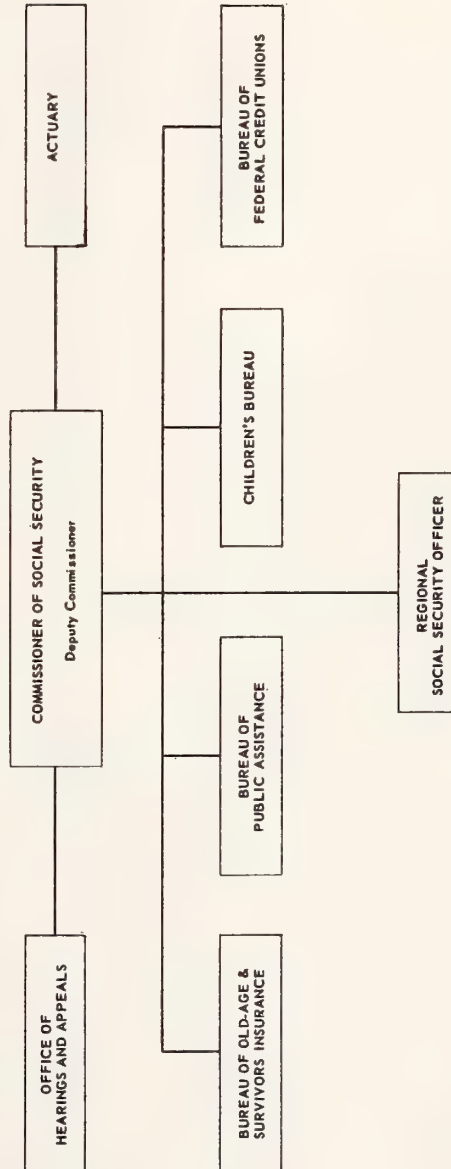


CHART C.—BUREAU OF OLD AGE AND SURVIVORS INSURANCE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social Security Administration
Bureau of Old-Age and Survivors Insurance

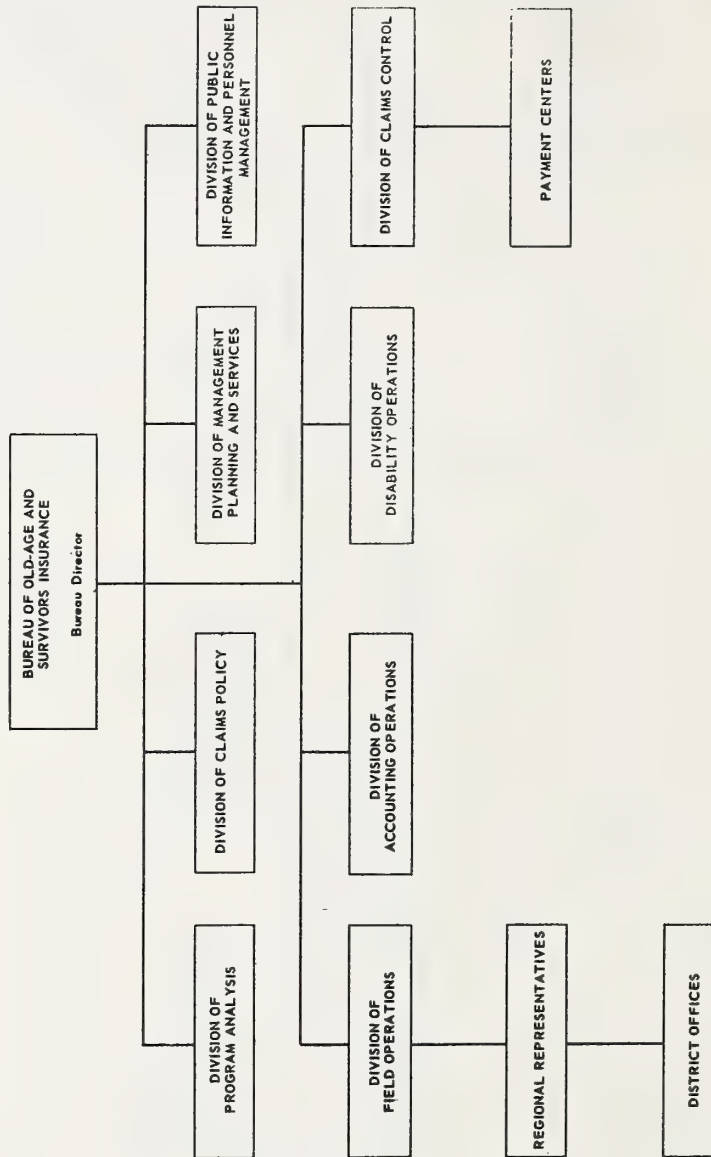
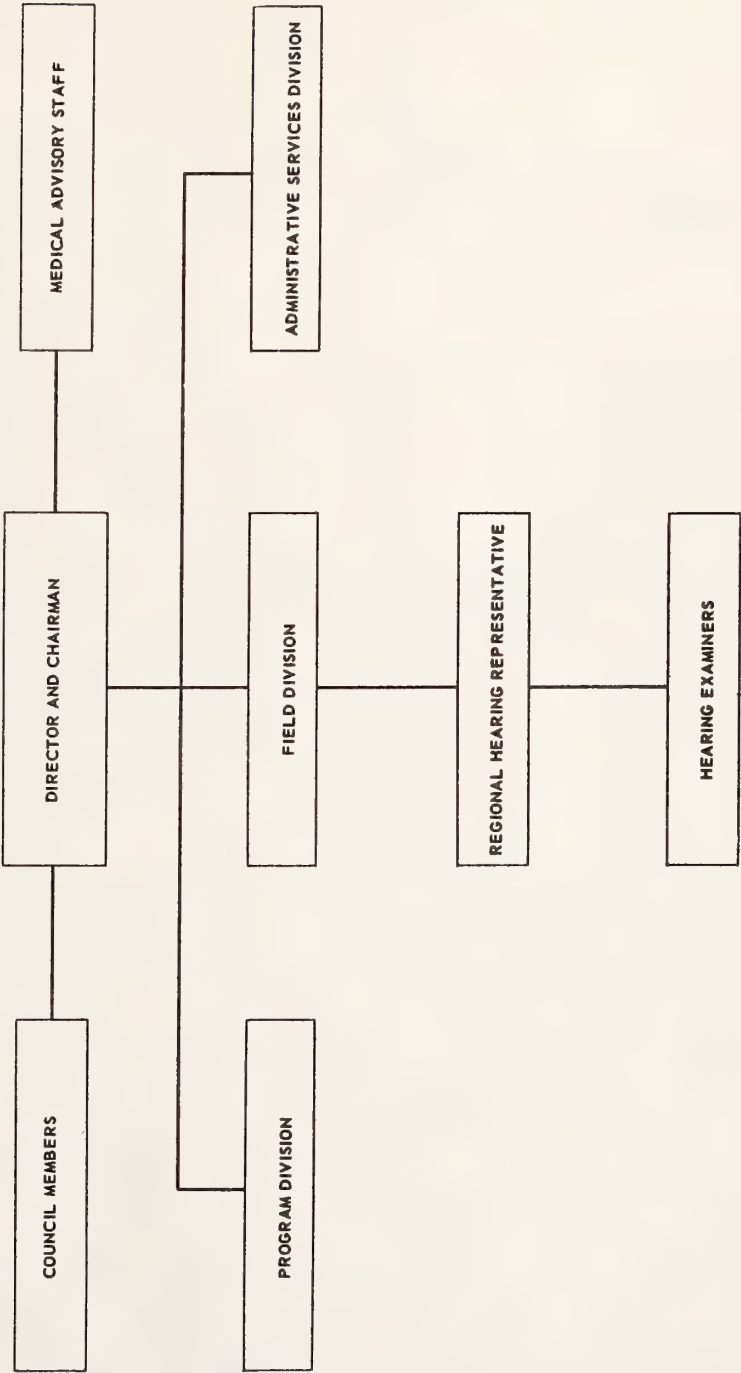


CHART D.—OFFICE OF HEARINGS AND APPEALS ORGANIZATION CHARTS



PART VIII

BASIC ASSUMPTIONS FOR ACTUARIAL COST ESTIMATES OF DISABILITY BENEFITS AND ANALYSIS OF CURRENT EX- PERIENCE

(By Robert J. Myers, Chief Actuary, Social Security Administration)

It is much more difficult to select reasonable assumptions for disability cost estimates for a new program than is the case in regard to programs providing retirement and survivor benefits. The latter are influenced primarily by such factors as mortality and retirement rates, which can be quite accurately estimated within a relatively narrow range of variation. On the other hand, rates of becoming disabled and rates of mortality and recovery for disabled persons are subject to very wide fluctuations. They are affected by such elements as interpretation of the definition of disability, economic conditions, public awareness of the benefits available, and psychological outlook of the covered persons. In fact, it has been quite properly stated that the potential disability cost burden of a proposed disability benefit program can be determined only by instituting the plan and then studying the experience thereunder. But this must be qualified to the extent that the early experience is not always necessarily sufficient to give a complete or accurate picture (as many past disability experiences have evidenced).

In preparing the cost estimates for the disability benefits in the OASDI system, as included by the 1956 amendments, a rather wide range was selected for the assumed cost factors. In the high-cost estimates, disability incidence rates for men are based on the so-called "165 percent modification of class 3" rates (which include increasingly higher percentages for ages above 45); this set of rates corresponds roughly to the life insurance company experience during the early 1930's. Incidence rates assumed for women are 100 percent higher than for men. Termination rates are "class 3" rates, which are also relatively high—to be consistent with the high incidence rates assumed.

For the low-cost estimates, disability incidence rates for men are based on 25 percent of those used in the high-cost estimates or, in other words, about 45 percent of the class 3 rates. Incidence rates assumed for women are 50 percent higher than for men. Termination rates are based on German social insurance experience for 1924-27, which is the best available recorded experience with relatively low disability termination rates (and therefore consistent for use with low incidence rates).

The incidence rates actually used for both estimates are 10 percent below the above basic rates because—unlike the general definition in insurance company policies—disability is not presumed after 6 months to be total and of expected long-continued duration but, rather, permanence must be proved at that time. It should be emphasized that the estimates have been based on percentages of insurance company

rates of incidence not because it was anticipated that OASDI experience would necessarily correspond therewith. Rather, this was done only after analysis and comparison of many other disability experiences—the use of modified insurance company rates simplified the computational processes.

It will be noted that the low-cost estimate assumes low incidence rates (which, taken by themselves, produce low costs) and also low termination rates (which, taken by themselves, produce higher costs, but which are considered to be necessary since with low incidence rates there would tend to be low termination rates because of few recoveries). On the other hand, the high-cost estimate is based on high incidence rates that are somewhat offset by high termination rates (the result of many recoveries).

No major basic modifications have been made in these cost assumptions subsequent to the enactment of the 1956 amendments. The actual experience to date under the strict definition of “disability” in the law has been somewhat lower costwise than the intermediate-cost assumptions would indicate and in fact has been very close to the low-cost assumptions.

The fact that the disability insurance trust fund has built up to a very sizable amount is not in itself evidence of low-cost experience. It had been anticipated under all cost estimates that, as the benefit roll slowly developed, there would be a considerable growth of the trust fund. Some indication of the relationship of the actual experience with the long-range cost estimates is given in tables 1 and 2.

Table F relates to the provisions in effect under the 1956 act, with suitable modifications in the data for calendar year 1958, so as to reflect what would have been the experience in that year if the 1958 amendments had not become effective in the latter part of the year. Although some allowance was made in the estimates for administrative and filing lag for 1957, apparently this was not sufficiently done, and the ratio of actual payments to estimated ones was relatively low. In 1958, however, the actual experience was very close to the low-cost estimate, and it is possible that if the law had remained unchanged, the actual experience for 1959 would be above the low-cost estimate (but, of course, still below the intermediate-cost estimate).

Table G, which relates to the cost estimates made for the 1958 act at the time it was enacted, indicates that it is likely that the actual benefit experience for 1959 will be quite close to the intermediate-cost estimate. It should be noted, however, that this is not necessarily an indication that the intermediate-cost estimate will reflect the actual future long-range experience because—unlike the original estimates for the 1956 act—the estimates for the early years of operation under the 1958 act were blended over a period of years from the current experience (during 1958) into the long-range estimates based on the foregoing assumptions.

In my opinion, until more experience is available and can be analyzed, the foregoing cost bases for the monthly disability benefits should be continued. In order to maintain the actuarial soundness of the disability insurance system, I believe that any substantive amendments should be entirely financed by one or more of such methods as (a) an increase in the contribution rate, (b) an increase in the maximum earnings base, (c) an increase in the basis for determining interest earnings of the trust fund, and (d) more favorable operating experience

in respect to such actuarial cost factors as level of earnings. However, it should be recognized that the present experience, if continued, justifies use of the present low-cost assumptions as the basis for the intermediate-cost estimate. Thus, if there were to be any increase in contributions for liberalization of these provisions put in the law, this could be done as a deferred increase rather than an immediate one, with the recognition that any stepup planned for the future might not be necessary if the experience continues at present levels.

There are a number of reasons why the disability experience might become more unfavorable (i.e., moving in the direction of producing higher costs). Conversely, in my opinion, there is relatively less likelihood that it will become more favorable (i.e., moving in the direction of producing lower costs). Among the factors that can lead to relatively higher cost experience—as has been almost universally the case in disability benefit programs throughout the world—are the following: (1) Greater public awareness of the benefits; (2) increased knowledge of how to claim the benefits so as to obtain favorable decisions; and (3) liberalization in the interpretation of the definition of "disability" by court action, congressional suggestions, and other means. On the other hand, there are some factors that can lead to relatively lower cost experience than at present, including the following: (1) Greater application of vocational rehabilitation (thus removing individuals from the benefit roll more rapidly than now anticipated); (2) a lower level of general invalidity due to medical advances (both preventative of invalidity and curative thereof); and (3) less invalidity as general mortality improves (although this would not necessarily follow since, for example, women have lower mortality than men, but higher morbidity).

TABLE F.—Comparison of actual ¹ and estimated experience under disability insurance program under provisions of 1956 act, 1957–58

Item	Contributions		Payments		Trust fund at end of year	
	1957	1958	1957	1958	1957	1958
Absolute figures (in millions)						
Actual experience ¹	\$702	\$966	\$57	\$235	\$649	\$1,393
Low-cost estimate.....	724	902	73	239	645	1,315
Intermediate-cost estimate.....	721	898	116	379	592	1,104
High-cost estimate.....	718	894	160	520	535	887
Ratio of actual to estimated figures						
	Percent	Percent	Percent	Percent	Percent	Percent
Low-cost estimate.....	97	107	78	98	101	106
Intermediate-cost estimate.....	97	108	49	62	110	126
High-cost estimate.....	98	108	36	45	121	157

¹ Data for 1958 actual experience adjusted to allow for fact that for September to December, actual disbursements were higher than they would have been under 1956 act, because of liberalizations in 1958 act effective then (primarily, the elimination of the "offset" provision and the addition of dependents benefits).

TABLE G.—Comparison of actual ¹ and estimated experience under disability insurance program under provisions of 1958 act, 1958-59

Item	Contributions		Payments		Trust fund at end of year	
	1958	1959	1958	1959	1958	1959
Absolute figures (in millions)						
Actual experience ¹	\$966	\$975	\$249	\$450	\$1, 379	\$1, 950
Low-cost estimate.....	915	982	238	352	1, 333	1, 999
Intermediate-cost estimate.....	914	980	263	431	1, 306	1, 887
High-cost estimate.....	913	979	287	511	1, 280	1, 776
Ratio of actual to estimated figures						
	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>
Low-cost estimate.....	106	99	105	128	103	98
Intermediate-cost estimate.....	106	99	95	104	106	103
High-cost estimate.....	106	100	87	88	108	110

¹ Data for 1959 actual experience is estimated on basis of experience to date.

PART IX

SUMMARY OF STATUTORY PROVISIONS UNDER TITLE II OF THE SOCIAL SECURITY ACT RELATING TO DISABILITY

DISABILITY INSURANCE BENEFITS

CONDITIONS OF ENTITLEMENT

The Social Security Act provides for the payment of a monthly disability insurance benefit to an entitled individual. An individual is entitled if he is insured; has attained the age of 50, but has not as yet attained the age of 65; is under a disability; files an application. These benefits are paid beginning with the first month after a waiting period and ending with the month preceding the first month in which any of the following events occurs: the individual's disability ceases; he dies; he attains the age of 65; or, in the case of a woman, she becomes entitled to old-age insurance benefits between ages 62 and 65. The amount of the benefit is equal to the amount that would have been paid to the individual had he (or she) reached 65 and become entitled to old-age insurance benefits in the first month of his waiting period.

DEFINITION OF "INSURED," "DISABILITY," AND "WAITING PERIOD"

An individual is insured in a particular month if he is a fully insured individual in that month and if he has not less than 20 quarters of coverage in the 40-quarter period ending with the quarter in which such month occurs. Such 40-quarter period does not include quarters in a period of disability (see item 2).

An individual is under a disability if he is unable "to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration."

An individual's waiting period is the earliest period of 6 consecutive calendar months throughout which the individual has been under a disability, provided such disability continues until he files an application for disability insurance benefits and he is insured in the first month of such period. This waiting period can start no earlier than the first day of the 18th calendar month before the application is filed and in no event earlier than the first day of the 6th calendar month before the individual attains age 50. Where the first calendar month after the waiting period precedes the month in which the application for disability benefits is filed, benefits are payable retroactively as though the application had been filed during such first month. This can never cover more than 12 months' benefits owing to the definition of the waiting period.

BENEFITS OF DEPENDENTS OF DISABILITY INSURANCE BENEFICIARY

Where an individual is entitled to disability insurance benefits, benefits will also be paid to his dependents in the same manner and to the same extent that benefits are paid to dependents of an old-age

insurance beneficiary. Thus, subject to the maximum payable to a family (and subject to actuarial reduction in the case of a wife aged 62-64) the eligible wife or husband is entitled to one-half the benefit payable to the disability insurance beneficiary and each child is also entitled to one-half of such benefit.

FUNDS FROM WHICH BENEFITS ARE PAID

Benefits are payable to a disability insurance beneficiary and his dependents from funds in the Federal Disability Insurance Trust Fund which is held separate from the funds in the Federal Old-Age and Survivors Insurance Trust Fund. The rate of contributions to the Federal Disability Insurance Trust Fund is one-half of 1 percent on wages (an employer rate of one-fourth of 1 percent and an employee rate of one-fourth of 1 percent) and three-eighths of 1 percent on the earnings of the self-employed, up to the maximum taxable earnings of \$4,800 a year.

References: Social Security Act, sections 223; 202 (b), (c), and (d); 201; 203.

PERIOD OF DISABILITY ("FREEZE")

CONDITIONS FOR ESTABLISHING A PERIOD OF DISABILITY

The Social Security Act also provides for the establishment of a period of disability (sometimes called disability "freeze"), the effect of which is to preserve the benefit rights (insured status and amount of benefit) of an individual under the old-age, survivors, and disability insurance program. (It is analogous to the "waiver of premium" commonly used in life insurance policies to maintain protection of the policies for the duration of the policyholder's disability.) Unlike the age limitation in the case of disability insurance benefits, a period of disability may be established for any period the individual is under 65, irrespective of whether he is over 50 years of age. Thus, even though an individual is entitled to disability insurance benefits (he is over 50 years of age), a period of disability will also be established for him to protect his old-age insurance benefits when he reaches retirement age, or if he dies, the benefits payable to his survivors.

A period of disability will be established for an individual if he is insured; he is under a disability for at least 6 consecutive calendar months before age 65; and he files an application while under such disability.

DEFINITIONS

Insured status requirements for a period of disability are the same as for disability insurance benefits. Likewise, the definition of disability is the same as the definition of disability for the purpose of disability insurance benefits, except that blindness is presumed to be a disability whether or not it prevents the individual from engaging in any substantial gainful activity. Blindness is defined as central visual acuity of 5/200 or less in the better eye with the use of a correcting lens; an eye in which the visual field is reduced to 5 degrees or less concentric contraction is considered as having a central visual acuity of 5/200 or less.

BEGINNING AND ENDING OF PERIODS OF DISABILITY

A period of disability begins on whichever of the following days is the latest—the day the disability began, the first day of the 18-month period preceding the day the individual files his application to establish a period of disability, or the first day of the first quarter thereafter in which he is insured for a period of disability—and ends with the last day of the first month in which the individual ceases to be under a disability, or attains the age of 65, whichever first occurs. The limitation of the 18-month period does not apply so long as an application to establish a period of disability is filed before July 1961.

EFFECT OF PERIOD OF DISABILITY

The effect of a period of disability is to preserve an individual's insured status for benefit purposes and also to prevent the reduction of the amount of his benefit because of his failure to have earnings during the period of disability. The following examples explain in further detail how this objective is achieved through the establishment of a period of disability.

Insured status.—In general, an individual is fully insured for benefit purposes if he has at least 6 quarters of coverage, and 1 quarter of coverage for every 2 quarters elapsing after December 31, 1950, and before the first day of the quarter in which he attains age 65 (or age 62 for women) or dies, whichever first occurs, except that once he has earned 40 quarters of coverage he is fully insured permanently. The longer the elapsed period, the more quarters of coverage an individual needs to be fully insured. Where a period of disability is established, the number of quarters in the elapsed period is decreased by the number of quarters included in the period of disability, thus reducing the number of quarters of coverage the individual must earn to be insured. Accordingly, a fully insured individual maintains that status during the time he is under a period of disability even though that period covers many years.

Protection of benefit level.—The amount of an individual's benefit is related to his average monthly wage. This is determined by averaging his earnings between two specified dates. For example, as the general rule, in the case of old-age insurance benefits, these dates can be December 31, 1950, and the first day of the year of attainment of age 65 (or 62 in the case of women). Low or no earnings at any time between these two specified dates can depress the average monthly wage and thus lower the benefit amount. Where the individual has established a period of disability between such dates, the years over which the average is computed do not include the years covered by the period of disability. The elimination of these years—usually years of no earnings—and the computation of the average monthly wage over periods when the individual's earnings were not cut off by disability thus prevents the average monthly wage from being lowered by reason of the period of disability.

Earnings credited to an individual during a period of disability are not counted in computing the average monthly wage, except that if an individual would have a higher average monthly wage by including earnings credited during the period of disability, his average monthly wage is computed without regard to such period.

References: Social Security Act, sections 216(i); 214; 215(b); 220.

CHILDHOOD DISABILITY BENEFITS

ELIGIBILITY TO BENEFITS

The Social Security Act provides for the payment of monthly benefits to the dependent child of an old-age insurance beneficiary, disability insurance beneficiary, or a deceased insured worker when the child is under a disability. The general rule is that benefits are payable to a child only so long as he is under 18. Where, however, the child is under a disability which began before he attained the age of 18, benefits are payable to that child regardless of his age. Such childhood disability benefits are terminated for the same reasons (except age) that benefits are terminated for a child under the age of 18, e.g., death, adoption by certain individuals, etc. In addition, such benefits will be terminated if the disability ceases.

DEFINITIONS OF DISABILITY AND DEPENDENCY

The definition of disability for childhood disability benefits is the same as the definition of disability for paying disability insurance benefits. In determining whether a child seeking childhood disability benefits is dependent upon the wage earner, a condition of entitlement to child's insurance benefits (under age 18) and childhood disability benefits, the rules for determining such dependency are the same as in the case of a child under 18.

FUNDS FROM WHICH BENEFITS ARE PAID

Childhood disability benefits in the case of a dependent child of an old-age insurance beneficiary or a deceased insured worker are payable from funds in the Federal Old-Age and Survivors Insurance Trust Fund.

Reference: Social Security Act, sections 201(h); 202(d).

AUTHORITY TO MAKE DETERMINATIONS OF DISABILITY

Determinations of disability with respect to disability insurance benefits, periods of disability, and childhood disability benefits are usually made by a State pursuant to an agreement entered into by the State and the Secretary of Health, Education, and Welfare under which the State, through its vocational rehabilitation agency or some other appropriate agency, agrees to make such determinations of disability with respect to all individuals in the State, or such class or classes of individuals in the State designated in the agreement. The Secretary makes determinations of disability with respect to any class or classes of individuals in a State not covered by the agreement and in the case of individuals outside the United States. A determination of disability made by a State agency that an individual is under a disability may be reviewed by the Secretary and after such review, the Secretary may determine that the individual is not under a disability, that the disability began on a later day, or that it ceased on an earlier day. However, unfavorable action by a State agency can be changed only by the agency itself or on the basis of appeal to a hearing examiner by the applicant.

Each State having an agreement with the Secretary receives money from the trust funds to cover the costs it incurs in making these determinations of disability.

Reference: Social Security Act, section 221.

REHABILITATION

The act sets forth a policy of the Congress that individuals who apply for determinations of disability or are entitled to childhood disability benefits should be promptly referred to the State for rehabilitation so that the maximum number of these individuals may be rehabilitated into productive activity. Where an individual refuses without good cause to accept rehabilitation services available to him under a State plan for vocational rehabilitation, his benefits and the benefits payable to his dependents are withheld for each month in which he refuses such services.

Where an individual is rendering services pursuant to a program for rehabilitation carried on under a State plan approved under the Vocational Rehabilitation Act, he is not to be regarded as being able to engage in substantial gainful activity solely by reason of these services, except that this exception applies only for the first 12 months in which the services are rendered.

Reference: Social Security Act, section 222.

PART X
GENERAL STATISTICAL INFORMATION ON DISABILITY
INSURANCE PROGRAM

STATE AGENCY OPERATIONS

STATE AGENCY DENIAL RATES: APRIL-JUNE 1959 AND JULY-SEPTEMBER
1958

A. General

The attached tables contain selected data on disability denial rates nationally and in individual States. Table H shows current denial rates State by State for the April-June 1959 quarter. These figures are summarized in table I which also contains comparative figures for the July-September 1958 quarter.

All of the figures are based on initial State determinations for disabled worker applicants (disability freeze and benefits) reviewed and effectuated in the Bureau during the specified time periods. Childhood disability benefit cases are excluded because, though small in number, they would distort the data on worker applicants.¹ Reconsideration and hearing cases are also excluded. The denial rates shown here are based on the number and proportion of cases disallowed solely because of failure to meet the test of disability.

B. Summary of the data

During the period April-June 1959, 38.2 percent of the State agency cases were denied for failure to meet the disability test (table H). Denial rates for individual States during this quarter ranged from 26.3 percent to 54.2 percent (table I). However, close to half of the States fell within the range 35-45 percent. Moreover, while nearly one-third of the States fell above the 45 percent denial mark, the cases handled by these States represented less than one-fourth of the total number of State determinations during the quarter.

Examination of the comparative figures in table I shows that (1) the rate of denial in State agencies declined significantly between the first and fourth quarters of fiscal year 1959, while (2) the amount of variation between individual States also decreased.

Nationally, the average denial rate fell from 47.4 percent in July-September 1958 to 38.2 percent in April-June 1959. As previously noted, the proportion of denials State-by-State ranged from a low of 26.3 percent to a high of 54.2 percent in April-June 1959. This range of variation compared with a range of from 28.6 percent to 73 percent in the July-September 1958 quarter.

The dispersion in April-June 1959 denial rates indicates that about two-thirds of the State agencies can be expected to differ from the average for all States by only 5.3 percent or less; in July-September 1958, the comparable difference was 7.8 percent.

¹ Approximately 9 out of every 10 childhood applications result in allowance.

C. Factors influencing interstate differences in denial rates

The Bureau believes that the figures above indicate that over the past year such factors as their emphasis on fuller documentation (of nonmedical as well as medical factors), on increased use of consultative examinations, and on training of professional staff engaged in the making and reviewing of State agency determinations has resulted in materially less interstate variation and in lower denial rates. These changes, the Bureau states, may also be a reflection of better public understanding of the nature of the program, resulting in fewer applications from persons who clearly cannot meet the definition of disability. The amount of interstate variation that still exists is significant. Yet, the Bureau emphasizes, these figures do not necessarily support the conclusion that there are significant variations among States in the application of the standards.

The Bureau believes that some variation in denial rates is to be expected merely by virtue of the fact that the kinds of people who file applications differ from State to State, thus causing variations in State denial rates. Demographic characteristics such as age, sex, employment factors, type of impairment, and other factors related to the incidence of disability differ significantly among States. These differences are reflected in interstate variations in both filing rates and denial rates.

TABLE H.—*Number of State disability determinations effectuated in Bureau, April-June 1959, and number and percent denied by State*¹

State	Number of cases effectuated ²	Number of cases denied ²	Denied cases as percent of total
United States.....	72, 410	27, 652	38. 2
Alabama.....	1, 418	661	46. 6
Alaska.....	(³)	(³)	(³)
Arizona.....	525	159	30. 3
Arkansas.....	838	338	40. 3
California.....	5, 989	2, 535	42. 3
Colorado.....	447	179	40. 0
Connecticut.....	976	281	28. 8
Delaware:			
Vocational rehabilitation.....	154	55	35. 7
Blind.....	(³)	(³)	(³)
District of Columbia.....	339	181	53. 4
Florida.....	3, 056	1, 358	44. 4
Georgia.....	2, 278	1, 044	45. 8
Hawaii.....	261	116	44. 4
Idaho.....	187	75	40. 1
Illinois.....	2, 027	658	32. 5
Indiana.....	1, 719	666	38. 8
Iowa.....	711	280	39. 4
Kansas.....	560	224	40. 0
Kentucky.....	1, 785	844	47. 3
Louisiana.....	1, 372	679	49. 5

See footnotes at end of table, p. 109.

TABLE H.—*Number of State disability determinations effectuated in Bureau, April-June 1959, and number and percent denied by State*¹—Continued

State	Number of cases effectuated ²	Number of cases denied ²	Denied cases as percent of total
Maine.....	407	135	33. 2
Maryland.....	1, 482	724	48. 9
Massachusetts.....	1, 965	588	29. 9
Michigan.....	2, 546	819	32. 2
Minnesota.....	633	258	40. 8
Mississippi.....	862	406	47. 1
Missouri.....	2, 069	757	36. 6
Montana.....	247	126	51. 0
Nebraska.....	308	112	36. 4
Nevada.....	109	43	39. 4
New Hampshire.....	242	110	45. 5
New Jersey.....	2, 361	674	28. 5
New Mexico.....	308	143	46. 4
New York.....	8, 692	2, 568	29. 5
North Carolina.....	1, 789	874	48. 9
North Dakota.....	57	15	26. 3
Ohio.....	4, 534	1, 337	29. 5
Oklahoma.....	938	352	37. 5
Oregon.....	878	442	50. 3
Pennsylvania:			
Vocational rehabilitation.....	4, 074	1, 222	30. 0
Blind.....	(³)	(³)	(³)
Rhode Island.....	431	163	37. 8
South Carolina:			
Vocational rehabilitation.....	1, 181	467	39. 5
Blind.....	(³)	(³)	(³)
South Dakota.....	209	99	47. 4
Tennessee.....	1, 797	933	51. 9
Texas.....	3, 438	1, 324	38. 5
Utah.....	163	64	39. 3
Vermont.....	194	51	26. 3
Virginia.....	1, 370	507	37. 0
Washington.....	1, 062	421	39. 6
West Virginia.....	1, 462	793	54. 2
Wisconsin:			
Vocational rehabilitation.....	1, 491	554	37. 2
Blind.....	(³)	(³)	(³)
Wyoming.....	102	43	42. 2
Puerto Rico.....	315	166	52. 7

¹ Based on determinations for disability insurance benefit and freeze cases only; excludes childhood disability cases.

² Excludes cases denied for reasons other than failure to meet test of disability.

³ Number of cases processed, if any, was too small for computation of reasonably reliable denial rates.

TABLE I.—*State denial rates: Number and percent of jurisdictions by disability denial rate, July–September 1958 and April–June 1959*¹

Denial rate	July–September 1958		April–June 1959	
	Number of jurisdictions	Percent of jurisdictions	Number of jurisdictions	Percent of jurisdictions
All jurisdictions	² 51	100. 0	² 51	100. 0
25 to 29.9	2	3. 9	7	13. 7
30 to 34.9	0	0. 0	5	9. 8
35 to 39.9	4	7. 8	14	27. 5
40 to 44.9	10	19. 6	9	17. 6
45 to 49.9	16	31. 5	10	19. 6
50 to 54.9	13	25. 5	6	11. 8
55 to 64.9	4	7. 8	0	0. 0
65 to 74.9	2	3. 9	0	0. 0
National average	47. 4		38. 2	
Range	28. 6–73. 0		26. 3–54. 2	
Standard deviation ³ (percent)	± 7. 8		± 5. 3	

¹ Based on State disability determinations for disability insurance benefit and freeze cases only effectuated in Bureau during periods specified. Excludes cases denied for reasons other than failure to meet disability test.

² Excludes 5 State jurisdictions where number of cases processed was too small for computation of reasonably reliable denial rates.

³ A measure of variation about the average. The larger the value of the standard deviation, the larger the amount of variation about the average.

BUREAU REVIEW OF DETERMINATIONS

A. General

Bureau evaluators review all State determinations for consistency and conformity with policy and standards. (See Part V of this fact book for a description of the entire disability claims process.) Questioned cases are returned to the States for appropriate action. In these cases the Bureau may suggest that (a) the State agency reverse its initial finding; (b) the date of onset of disability be changed without any question about the finding; (c) in continuing disability cases the State reverse a decision terminating or continuing the disability status; or (d) in all types of cases that additional evidence, including purchase of a consultative medical examination in some cases, be obtained.

The attached tables contain data on the operation and effect of the Bureau's review of initial State agency determinations. Table J shows, for allowances and denials separately, the number and percent of cases during fiscal year 1959 in which Bureau reviewers questioned some aspect of State agency adjudication. "Return rates" are given for each quarter during the fiscal year. Table K presents current State-by-State return rates for the last quarter of fiscal year 1959. The figures in table L show the results of the Bureau's review of State determinations by showing the number and percent of questioned State agency denials that are ultimately allowed. The tables do not

contain any data on continuing disability cases. Experience with these cases is too recent to be significant.

B. Summary of data

Table J shows that the percent of initial State determinations questioned by the Bureau has increased during the past fiscal year—from 3.8 percent of all cases reviewed in July-September 1958 to 6.1 percent in April-June 1959. This increase has been due almost exclusively to increased return rates for State agency denials. Throughout fiscal year 1959, the return rate for State allowances was fairly constant at about 4.5 percent. In contrast, the proportion of State agency denials questioned by the Bureau rose from 3.2 percent at the beginning of the fiscal year to 8.9 percent in the last quarter of the fiscal year.

On a State-by-State basis also, current return rates for denials were higher than those for allowances in all except 13 State jurisdictions (table K). During April-June 1959, the percent of allowed cases questioned by the Bureau ranged from a low of 0.7 percent to a high of 15.4 percent. However, return rates for two-thirds of the agencies (35 out of 52 for which reliable rates could be computed) fell within the range 3.1 percent to 8.6 percent.

The amount of interstate variation was greater for denials. During the last quarter of the fiscal year, the proportion of denied cases questioned ranged from 0.7 percent to 19.2 percent. The rates for two-thirds of the States (32 out of 50 for which reliable rates could be computed) ranged from 6.1 percent to 13.9 percent. The Bureau believes that for the most part, the greater variability demonstrated by return rates for denials reflects the interstate variation in denial rates themselves. State-by-State comparison of these data with data on denial rates shows a correlation between high denial rates and high return rates.

Bureau review of State agency determinations brings about a change in a significant number of questioned State decisions and operates, in general, to reduce the overall denial rate. Thus, for all States combined about 68 percent of initial denials questioned by the Bureau were ultimately allowed; for allowances only about 29 percent were ultimately denied (table L). This pattern existed in all States for which reliable rates could be computed. The Bureau states that the change rate for allowances must be interpreted in light of the fact that in about 40 percent of the allowances questioned, the Bureau does not question the fact of allowance but only the correctness of the onset date (which may materially affect the amount of benefits due).

TABLE J.—Number of State agency determinations initially reviewed in fiscal year 1959, and number and percent of cases questioned for substantive reasons by calendar quarter and type of State agency finding

Calendar quarter	All cases				Allowed by States				Denied by States			
	Number re-viewed ¹	Cases questioned ²			Number re-viewed ¹	Cases questioned ²		Percent of total	Number re-viewed ¹	Cases questioned ²		Percent of total
		Number	Percent of total			Number	Percent of total			Number	Percent of total	
Fiscal year	301, 611	15, 316	5. 1		170, 403	7, 868	4. 6		131, 208	7, 448	5. 7	
July–September 1958.....	65, 221	2, 506	3. 8		34, 917	1, 534	4. 4		30, 304	972	3. 2	
October–December 1958.....	77, 426	3, 460	4. 5		40, 831	1, 952	4. 8		36, 595	1, 508	4. 1	
January–March 1959.....	71, 532	3, 991	5. 6		40, 440	1, 985	4. 9		31, 092	2, 006	6. 5	
April–June 1959.....	87, 432	5, 359	6. 1		54, 215	2, 397	4. 4		33, 217	2, 962	8. 9	

¹ The number of cases reviewed during the period is the sum of all State determinations effectuated by the Bureau without question during the period specified, plus the number of cases returned to the States because of some question or disagreement. Each case is counted only once in this table; the count is made as of the time of review.

² Figures on cases questioned are limited to those questioned for "substantive reasons." These are cases where the Bureau questions the State agency's finding or the adequacy of the evidence in file. Also in this category are allowances which are questioned not as to basic determination but only because an incorrect date of onset has apparently been established.

TABLE K.—*State determinations initially reviewed during April-June 1959: Number and percent questioned for substantive reasons¹ by type of State agency finding*

State agency	Allowed by States			Denied by States		
	Cases re-viewed	Cases questioned		Cases re-viewed	Cases questioned	
		Num-ber	Percent of total		Num-ber	Percent of total
United States.....	54, 215	2, 397	4. 4	33, 217	2, 962	8. 9
Alabama.....	920	37	4. 0	819	114	13. 9
Alaska.....	23	2	(²)	40	4	(²)
Arizona.....	417	23	5. 5	188	11	5. 9
Arkansas.....	591	26	4. 4	386	26	6. 7
California.....	3, 844	118	3. 1	2, 969	122	4. 1
Colorado.....	304	4	1. 3	247	46	18. 6
Connecticut.....	994	56	5. 6	344	9	2. 6
Delaware:						
Vocational rehabilitation.....	136	21	15. 4	58	5	8. 6
Blind.....	6	3	(²)	1	0	(²)
District of Columbia.....	172	13	7. 6	219	16	7. 3
Florida.....	1, 799	50	2. 8	1, 610	190	11. 8
Georgia.....	1, 439	57	4. 0	1, 186	85	7. 2
Hawaii.....	227	7	3. 1	150	1	. 7
Idaho.....	158	3	1. 9	107	18	16. 8
Illinois.....	1, 785	67	3. 8	826	103	12. 5
Indiana.....	1, 295	32	2. 5	834	103	12. 4
Iowa.....	570	15	2. 6	317	20	6. 3
Kansas.....	429	28	6. 5	258	25	9. 7
Kentucky.....	1, 180	97	8. 2	979	73	7. 5
Louisiana.....	815	37	4. 5	802	85	10. 6
Maine.....	339	15	4. 4	162	5	3. 1
Maryland.....	869	65	7. 5	839	58	6. 9
Massachusetts.....	1, 699	86	5. 1	772	105	13. 6
Michigan.....	2, 038	67	3. 3	984	136	13. 8
Minnesota.....	514	21	4. 1	356	58	16. 3
Mississippi.....	538	38	7. 1	511	71	13. 9
Missouri.....	1, 520	84	5. 5	895	107	12. 0
Montana.....	147	9	6. 1	157	19	12. 1
Nebraska.....	258	21	8. 1	138	12	8. 7
Nevada.....	65	4	6. 2	46	3	(²)
New Hampshire.....	157	7	4. 5	132	16	12. 1
New Jersey.....	1, 932	51	2. 6	880	91	10. 3
New Mexico.....	198	10	5. 1	151	4	2. 6
New York.....	7, 516	202	2. 7	3, 057	140	4. 6
North Carolina.....	1, 152	42	3. 6	1, 006	61	6. 1
North Dakota.....	91	9	9. 9	31	3	(²)
Ohio.....	3, 684	146	4. 0	1, 595	100	6. 3
Oklahoma.....	662	18	2. 7	456	54	11. 8
Oregon.....	505	13	2. 6	494	23	4. 7

See footnotes at end of table, p. 114.

TABLE K.—State determinations initially reviewed during April-June 1959: Number and percent questioned for substantive reasons ¹ by type of State agency finding—Continued

State agency	Allowed by States			Denied by States		
	Cases reviewed	Cases questioned		Cases reviewed	Cases questioned	
		Number	Percent of total		Number	Percent of total
Pennsylvania:						
Vocational rehabilitation---	3,724	319	8.6	1,386	164	11.8
Blind-----	191	15	7.9	124	20	16.1
Rhode Island-----	352	42	11.9	181	5	2.8
South Carolina:						
Vocational rehabilitation---	780	21	2.7	531	59	11.1
Blind-----	18	3	(²)	11	3	(²)
South Dakota-----	159	9	5.7	105	6	5.7
Tennessee-----	1,014	50	4.9	1,166	176	15.1
Texas-----	2,456	76	3.1	1,582	129	8.2
Utah-----	138	1	.7	80	6	7.5
Vermont-----	182	11	6.0	58	2	3.4
Virginia-----	1,008	79	7.8	574	39	6.8
Washington-----	782	32	4.1	511	10	2.0
West Virginia-----	834	77	9.2	988	136	13.8
Wisconsin:						
Vocational rehabilitation---	1,185	24	2.0	657	56	8.5
Blind-----	46	1	(²)	6	2	(²)
Wyoming-----	76	15	19.7	52	10	19.2
Puerto Rico-----	282	18	6.4	203	17	8.4

¹ Cases where Bureau questions the conclusion reached by the State agency or the date of onset, or the adequacy of the evidence, etc.

² Number of cases too small for reliable percentages.

TABLE L.—Number of State agency allowances questioned and number and percent eventually denied, number of State agency denials questioned and number and percent eventually allowed ¹

State Agency	Questioned cases initially allowed by States	Allowed		Denied		
		Cases eventually denied		Questioned cases initially denied by States	Cases eventually allowed	
		Number	Percent of total questioned denied		Number	Percent of total questioned allowed
United States.....	3, 517	1, 014	28. 8	3, 261	2, 218	68. 0
Alabama.....	70	15	21. 4	83	45	54. 2
Alaska.....	2	0	(2)	3	3	(2)
Arizona.....	22	5	(2)	15	11	(2)
Arkansas.....	54	17	31. 5	28	20	(2)
California.....	177	41	23. 2	170	94	55. 3
Colorado.....	6	1	(2)	28	19	(2)
Connecticut.....	48	5	(2)	26	13	(2)
Delaware:						
Vocational rehabilita-						
tion.....	36	16	(2)	8	4	(2)
Blind.....	1	0	(2)	0	0	0
District of Columbia.....	22	6	(2)	10	3	(2)
Florida.....	102	24	23. 5	111	76	68. 5
Georgia.....	75	17	22. 7	76	50	65. 8
Hawaii.....	22	11	(2)	5	3	(2)
Idaho.....	2	1	(2)	1	0	(2)
Illinois.....	184	68	37. 0	100	77	77. 0
Indiana.....	54	13	24. 1	120	82	68. 3
Iowa.....	26	8	(2)	27	23	(2)
Kansas.....	42	21	(2)	35	24	(2)
Kentucky.....	101	19	18. 8	61	40	65. 6
Louisiana.....	79	26	32. 9	51	39	76. 5
Maine.....	17	10	(2)	6	5	(2)
Maryland.....	92	25	27. 2	82	48	58. 5
Massachusetts.....	131	21	16. 0	103	70	68. 0
Michigan.....	59	11	18. 6	155	120	77. 4
Minnesota.....	31	4	(2)	37	17	(2)
Mississippi.....	63	11	17. 5	79	54	68. 4
Missouri.....	120	29	24. 2	161	110	68. 3
Montana.....	15	4	(2)	13	10	(2)
Nebraska.....	37	11	(2)	38	27	(2)
Nevada.....	11	3	(2)	7	4	(2)
New Hampshire.....	10	3	(2)	15	8	(2)
New Jersey.....	180	53	29. 4	142	96	67. 6
New Mexico.....	15	5	(2)	9	5	(2)
New York.....	356	103	28. 9	255	163	63. 9
North Carolina.....	79	26	32. 9	85	60	70. 6
North Dakota.....	15	9	(2)	5	4	(2)
Ohio.....	127	38	29. 9	126	102	81. 0

See footnotes at end of table, p. 116.

TABLE L.—Number of State agency allowances questioned and number and percent eventually denied, number of State agency denials questioned and number and percent eventually allowed ¹—Continued

State Agency	Questioned cases initially allowed by States	Allowed		Denied		
		Cases eventually denied		Questioned cases initially denied by States	Cases eventually allowed	
		Number	Percent of total questioned denied		Number	Percent of total questioned allowed
Oklahoma.....	53	14	26. 4	71	57	80. 3
Oregon.....	14	3	(²)	33	21	(²)
Pennsylvania:						
Vocational rehabilitation.....	337	118	35. 0	180	118	65. 6
Blind.....	35	13	(²)	124	120	96. 8
Rhode Island.....	31	16	(²)	6	3	(²)
South Carolina:						
Vocational rehabilitation.....	32	5	(²)	76	48	63. 2
Blind.....	3	0	(²)	1	1	(²)
South Dakota.....	13	2	(²)	11	7	(²)
Tennessee.....	96	30	31. 3	112	76	67. 9
Texas.....	95	33	34. 7	105	64	61. 0
Utah.....	1	0	(²)	2	1	(²)
Vermont.....	6	2	(²)	1	1	(³)
Virginia.....	120	39	32. 5	101	68	67. 3
Washington.....	33	9	(²)	24	15	(²)
West Virginia.....	94	29	30. 9	77	48	62. 3
Wisconsin:						
Vocational rehabilitation.....	28	8	(²)	30	23	(²)
Blind.....	1	1	(²)	6	5	(²)
Wyoming.....	10	6	(²)	4	3	(²)
Puerto Rico.....	32	6	(²)	21	10	(²)

¹ Based on State determinations effectuated in Bureau January-June 1959.

² Too few cases for computation of reliable percentages.

STATE AGENCY STAFFING AND COSTS

TABLE M.—*Funds advanced to State agencies and end of year full-time personnel on disability work, by fiscal year*

Fiscal year	Fund advances to State agencies (in thousands) ¹	Full-time personnel on disability work end of year ²
1955.....	\$709	(³)
1956.....	1, 675	⁴ 284
1957.....	4, 457	655
1958.....	7, 341	837
1959.....	11, 239	1, 147

¹ Funds advanced to State agencies out of OASI funds during fiscal year.
² small State agencies, whose costs are included, operate on a reimbursable basis rather than on advances of funds. Advances during Federal fiscal year July-June largely finance State agency operations during October-September period.

² Does not include persons in State agencies engaged in OASI disability work on less than a full-time basis.

³ Data not available.

⁴ First reported data available for Sept. 30, 1956.

TABLE N.—*Amount and percentage distribution of expenditures by State agencies, by object classes, during July 1, 1958–June 30, 1959, period*

Object class	Amount (in thousands)	Percent of total
Total.....	¹ \$9, 789	100. 0
Personal services.....	5, 437	55. 5
Identifiable full-time.....	4, 250	43. 4
Other direct personal services.....	895	9. 1
Administration.....	292	3. 0
Travel.....	250	2. 5
Communications.....	158	1. 6
Supplies.....	115	1. 2
Rent.....	339	3. 5
Office maintenance.....	35	. 4
Equipment purchases.....	306	3. 1
Medical evidence costs.....	2, 994	30. 6
Medical examinations.....	2, 963	30. 3
Transportation of applicants, medical ab- stracts and other evidence.....	31	. 3
Other.....	155	1. 6

¹ Total and its distribution by object classes partially estimated. Financial reports from several agencies for April-June 1959, period not yet available. The sum of \$10 million was advanced by the Bureau for use during the July 1958-June 1959 period. The difference between this amount and the amount reported as expended represents an increase in the unexpended balances on hand in the State agencies for use in subsequent periods.

TABLE O.—*Jurisdiction of cases involving substantive disability determinations, calendar years 1955–58, inclusive by year and 1st 6 months of 1959*

Year	Percent of cases ¹		
	Total	State jurisdiction as percent of total	Bureau jurisdiction as percent of total
All years.....	100	65. 0	35. 0
1955.....	100	17. 2	82. 8
1956.....	100	52. 3	47. 7
1957.....	100	77. 5	22. 5
1958.....	100	81. 9	18. 1
January–June 1959.....	100	90. 6	9. 4

¹ Percentages are estimated on the basis of clearances from district offices during the periods shown. They will, therefore, not agree with figures that are derived using as a base determinations actually made by the States and the Bureau of Old-Age and Survivors Insurance during the periods shown.

TABLE P.—*Unit costs ¹ for disability claims initially adjudicated by State agencies for fiscal years 1958–61 ²*

	Development by district offices	Adjudication by State agencies ³	Review by Bureau of Old-Age and Survivors Insurance
Fiscal year 1958.....	\$20. 65	\$16. 53	\$3. 82
Fiscal year 1959.....	21. 73	18. 23	5. 61
Fiscal year 1960 (estimate).....	23. 66	16. 99	5. 75
Fiscal year 1961 (estimate).....	24. 14	17. 31	5. 94

¹ Minor costs incurred by Division of Accounting Operations and the payment centers of the Bureau of Old-Age and Survivors Insurance have been excluded from these costs.

² The types of cases initially adjudicated by the Bureau of Old-Age and Survivors Insurance are not comparable to those processed through the States. Today, about two-thirds of the cases sent directly to the Bureau involve disallowances for technical reasons and do not require determinations of disability; e.g., no medical evidence submitted. A small percentage of the cases sent directly to the Bureau do require disability determinations as in the typical case adjudicated by the States. In the very few of these cases in which a consultative examination appears in order, the case is transferred to the State agency for such examination and the making of the initial determination of disability. The unit cost data on this table reflects these significant dissimilarities in the caseload.

³ All cost data for State agencies exclude cost of purchase of consultative medical examinations.

TABLE Q.—Selected data on State agency operations for fiscal year 1959

State and agency	Expenditures (in thousands)		Average number of employees on disability work ¹	Disability cases completed		Percent of all cases ² which require additional evidence	
	Total	Medical examinations		Total	Initial determinations	Evidence of all types ³	Purchase of medical evidence
United States.....	\$9,789.4	\$2,963.0	1,143.7	402,952	269,170	46.9	21.6
Alabama.....	203.8	85.1	19.3	8,524	6,052	46.8	21.8
Alaska.....	6.1	.7	.8	225	149	26.2	9.3
Arizona.....	92.3	24.8	10.1	3,083	2,249	47.4	25.6
Arkansas.....	114.7	38.8	12.5	4,595	3,354	57.6	25.7
California.....	903.0	252.5	87.4	32,491	23,942	42.2	15.0
Colorado.....	40.1	5.6	5.7	2,801	2,110	35.3	4.2
Connecticut.....	127.6	10.6	18.1	5,445	4,084	31.1	11.3
Delaware:							
Vocational rehabilitation.....	16.5	3.1	2.6	915	660	33.0	9.8
Blind.....	8	0	.1	26	15	30.8	11.5
District of Columbia.....	40.1	8.7	4.1	1,625	1,234	50.8	18.2
Florida.....	307.0	114.3	31.0	12,784	9,374	46.1	27.5
Georgia.....	298.5	116.3	28.6	11,064	8,110	49.1	27.1
Hawaii.....	25.4	4.6	5.1	1,070	868	34.9	18.0
Idaho.....	21.2	6.0	2.5	1,173	867	30.8	10.7
Illinois.....	520.2	143.9	63.8	16,220	11,470	57.3	17.9
Indiana.....	165.4	81.9	16.8	9,827	6,985	58.3	25.0
Iowa.....	83.8	20.0	11.6	4,263	3,247	58.2	26.5
Kansas.....	117.3	34.2	14.7	3,727	2,815	50.7	21.0
Kentucky.....	281.9	108.2	31.4	9,739	6,807	40.5	33.6
Louisiana.....	153.3	36.0	17.5	7,305	5,440	45.3	20.3
Maine.....	38.6	8.4	4.8	2,272	1,667	43.6	12.9

Maryland.....	138.1	62.6	11.7	6,736	4,994	47.1	28.4
Massachusetts.....	242.0	48.2	41.5	12,960	9,227	41.2	13.2
Michigan.....	358.0	134.4	38.1	14,643	10,883	47.8	21.8
Minnesota.....	118.1	24.8	13.6	4,023	3,015	51.1	11.0
Mississippi.....	128.2	25.3	14.5	5,613	3,563	49.1	27.1
Missouri.....	294.4	129.6	28.5	10,987	8,057	48.3	28.3
Montana.....	25.6	1.7	4.0	1,386	1,018	11.3	3.2
Nebraska.....	48.5	7.1	7.1	2,407	1,746	44.2	10.9
Nevada.....	22.9	7.1	2.3	566	394	51.4	29.9
New Hampshire.....	42.8	4.5	5.7	1,353	973	50.3	13.2
New Jersey.....	371.6	118.1	43.9	14,300	10,629	43.8	26.3
New Mexico.....	37.6	14.3	3.2	1,586	1,172	40.4	22.0
New York.....	1,003.1	220.8	140.7	45,612	33,958	43.9	18.8
North Carolina.....	271.3	99.8	27.3	10,160	7,359	54.6	23.5
North Dakota.....	23.0	7.6	2.3	586	434	63.5	59.0
Ohio.....	460.7	172.6	56.1	21,865	16,687	53.5	22.0
Oklahoma.....	128.9	31.9	21.5	5,820	4,269	47.6	22.8
Oregon.....	122.4	27.9	16.9	4,569	3,414	56.5	19.3
Pennsylvania:							
Vocational rehabilitation.....	626.1	170.6	68.3	25,337	18,884	51.4	30.9
Blind.....	32.0	6.2	3.4	1,728	1,209	28.9	14.4
Rhode Island.....	46.8	14.8	6.2	2,273	1,763	47.4	22.3
South Carolina:							
Vocational rehabilitation.....	181.7	58.8	19.8	6,442	4,647	46.9	22.7
Blind.....	2.0	(^b)	.3	139	96	37.4	8.6
South Dakota.....	27.2	8.2	3.3	906	709	53.2	20.8
Tennessee.....	179.2	56.1	22.9	10,372	7,256	41.7	21.7
Texas.....	440.1	158.8	45.6	17,006	12,706	46.0	19.8
Utah.....	30.8	5.7	4.1	908	720	50.0	17.3
Vermont.....	27.2	4.2	4.4	920	731	44.5	15.5
Virginia.....	164.0	69.3	19.5	8,866	6,394	46.1	27.2

See footnotes at end of table, p. 122.

TABLE Q—Selected data on State agency operations for fiscal year 1959—Continued

State and agency	Expenditures (in thousands)		Average number of employees on disability work ¹	Disability cases completed		Percent of all cases ² which require additional evidence	
	Total	Medical examinations		Total	Initial determinations	Evidence of all types ³	Purchase of medical evidence
Washington-----	150.9	31.9	17.6	6,219	4,712	55.9	11.4
West Virginia-----	230.9	75.4	29.5	7,695	5,444	46.4	30.4
Wisconsin:							
Vocational rehabilitation-----	200.0	42.0	24.6	7,304	5,688	39.4	15.4
Blind-----	2.5	(⁵)	.3	230	152	28.7	1.3
Wyoming-----	13.5	.4	2.0	529	410	46.9	5.9
Puerto Rico-----	39.6	17.6	4.5	1,732	1,358	50.4	42.0

¹ Includes employees engaged in disability work on a full-time basis, part-time basis and pro rata share of State agency administrative personnel, expressed in terms of full-time equivalents.

² Includes applications for initial disability determination, reconsideration and hearing requests, investigations of continuing eligibility and cases returned to State agencies by Bureau of Old-Age and Survivors Insurance.

³ Includes, among others, cases involving purchase of medical evidence presented in the next column.

⁴ Partially estimated. Financial reports from several State agencies for April-June 1959 period not yet available.

⁵ Less than \$50.

CASE PROCESSING TIME

TABLE R.—Average processing time in calendar days for disability cases by type of determination: Selected months ¹

Month and year	Initial determinations ²		Reconsideration requests ³		Hearing requests ³	
	Requiring State development	Not requiring State development	Affirmed	Reversed	Remanded	Handled by referees
December 1957 ⁴ -----	234	188	(⁵)	(⁵)	(⁵)	(⁵)
June 1958 ⁴ -----	172	131	⁶ (165)	⁶ (165)	⁷ 237	⁷ 290
December 1958 ⁴ -----	164	117	103	128	136	243
June 1959-----	160	107	103	129	172	250

¹ All processing times are measured by the number of calendar days elapsed from the date of application (or request for reconsideration or hearing) to the date of final decision (date of referee's decision in hearing cases). Figures for initial determinations relate to State cases only. Figures for reconsideration and hearing requests relate to both State and non-State cases. Non-State cases represent less than 5 percent of the total number of reconsideration and hearing requests. Averages are expressed in median days.

² Figures for initial determinations relate to cases involving payment of disability insurance benefits. Time for disallowance cases would generally be about 10 days less than the figures shown in the table.

³ The data include both cases requiring further development by the States and those not requiring further development.

⁴ Data for initial determinations are partly estimated for these months. Data for these months are partly derived from routine tabulations of State cases received in Baltimore during the months noted and partly estimated from sample studies of cases processed by the Bureau of Old-Age and Survivors Insurance in Baltimore. Beginning with June 1959, all data are derived from routine tabulation of cases processed at selected work stations.

⁵ Not available.

⁶ Figure for reconsideration requests for June 1958 represents both affirmed and reversed cases combined. Separate figures not available.

⁷ Figures for hearing requests for June 1958 actually represent results of sample study conducted in March 1958. Routine collection of data did not begin until August 1958.

TABLE S.—Average State agency processing time of disability cases, initial determinations, June 1959: All cases, cases requiring development, and cases not requiring development ¹

	All cases	Cases requiring development	Cases not requiring development
United States.....	40. 8	73. 1	20. 0
Alabama ²	57. 2	83. 0	44. 2
Alaska.....	(³)	(³)	(³)
Arizona.....	41. 0	48. 4	35. 1
Arkansas.....	34. 7	55. 7	(⁴)
California.....	42. 3	80. 3	22. 8
Colorado.....	51. 9	(⁵)	40. 1
Connecticut.....	46. 8	77. 0	37. 1
Delaware:			
Vocational rehabilitation.....	10. 8	84. 0	(⁴)
Blind.....	(³)	(³)	(³)
District of Columbia.....	57. 2	83. 1	23. 5
Florida.....	19. 9	52. 4	(⁴)
Georgia.....	40. 0	66. 0	13. 8
Hawaii.....	28. 4	69. 0	23. 8
Idaho.....	11. 9	26. 8	8. 0
Illinois ²	68. 8	(⁵)	33. 6
Indiana.....	39. 6	52. 9	25. 9
Iowa.....	48. 7	61. 0	30. 1
Kansas.....	47. 3	77. 2	22. 0
Kentucky.....	53. 7	86. 4	20. 5
Louisiana ²	94. 2	106. 1	74. 7
Maine.....	36. 0	65. 2	21. 5
Maryland.....	27. 2	57. 9	13. 9
Massachusetts.....	42. 1	64. 8	22. 9
Michigan.....	44. 8	85. 6	30. 7
Minnesota.....	78. 5	(⁵)	50. 1
Mississippi.....	36. 4	52. 2	32. 4
Missouri.....	28. 4	62. 1	15. 8
Montana.....	33. 6	(³)	33. 4
Nebraska.....	47. 4	67. 7	43. 1
Nevada.....	37. 3	(³)	(³)
New Hampshire.....	17. 0	45. 0	(⁴)
New Jersey.....	39. 1	51. 3	16. 0
New Mexico.....	12. 4	42. 6	(⁴)
New York.....	24. 2	60. 0	15. 9
North Carolina ²	104. 6	(⁵)	77. 3
North Dakota.....	33. 0	(³)	(³)
Ohio.....	44. 8	81. 7	23. 4
Oklahoma.....	16. 1	53. 1	(⁴)
Oregon.....	49. 2	93. 6	30. 3
Pennsylvania:			
Vocational rehabilitation.....	71. 1	102. 4	27. 8
Blind.....	(⁵)	(⁵)	(⁵)
Rhode Island.....	59. 4	71. 5	53. 5

See footnotes at end of table, p. 125.

TABLE S.—Average State agency processing time of disability cases, initial determinations, June 1959: All cases, cases requiring development, and cases not requiring development¹—Continued

	All cases	Cases requiring development	Cases not requiring development
South Carolina:			
Vocational rehabilitation.....	56.3	72.8	32.8
Blind.....	(³)	(³)	(³)
South Dakota.....	53.0	82.3	32.6
Tennessee.....	34.0	64.0	13.1
Texas.....	32.1	71.8	13.7
Utah.....	49.8	97.6	39.5
Vermont.....	13.7	51.0	(⁴)
Virginia.....	60.5	81.0	46.1
Washington.....	22.8	45.8	11.3
West Virginia.....	54.5	103.9	18.9
Wisconsin:			
Vocational rehabilitation.....	25.8	73.2	15.1
Blind.....	(³)	(³)	(³)
Wyoming.....	12.8	13.9	12.1
Puerto Rico.....	(⁵)	(⁵)	75.9

¹ Reported by State agencies. Figures based on initial determinations disposed of by the States during the month of June 1959. Processing time is measured from the date of receipt in the State to the date the case is forwarded to the Bureau of Old-Age and Survivors Insurance in Baltimore. Averages are expressed in median days.

² During this period cases were being transferred or diverted to the Bureau for adjudication under temporary emergency modifications of State agreements. Processing times for these States may therefore be distorted.

³ Number of cases too small for reliable computation.

⁴ 7 days or less.

⁵ Over 110 days.

TABLE T.—*Number and percent of State jurisdictions by average processing time, June 1959: Cases requiring development and cases not requiring development*¹

CASES REQUIRING DEVELOPMENT		
Average processing time (in days)	Number of jurisdictions	Percent of jurisdictions
All jurisdictions.....	² 49	100. 0
Under 20.....	1	2. 0
20 to 39.....	1	2. 0
40 to 59.....	12	24. 5
60 to 79.....	15	30. 7
80 to 99.....	11	22. 4
100 and over.....	9	18. 4
CASES NOT REQUIRING DEVELOPMENT		
All jurisdictions.....	³ 50	100. 0
Under 10.....	8	16. 0
10 to 19.....	11	22. 0
20 to 29.....	10	20. 0
30 to 39.....	11	22. 0
40 to 59.....	6	12. 0
60 and over.....	4	8. 0

¹ Data reported by State agencies, based on initial determinations disposed of by the States during the month of June 1959. Average processing time expressed in median days.

² Excludes 7 State jurisdictions where number of cases was too small for reliable computation.

³ Excludes 6 State jurisdictions where number of cases was too small for reliable computation.

VOCATIONAL REHABILITATION

REHABILITATION OF DISABILITY APPLICANTS BY STATE AGENCIES

General

The following tables contain selected data on the operation of the vocational rehabilitation referral program for disability applicants. Under this program, all disability applicants—including applicants for the disability freeze, for disability insurance benefits, and for childhood disability benefits—are referred to State vocational rehabilitation agencies for consideration for rehabilitation services. The State vocational rehabilitation agencies report to the Bureau of Old-Age and Survivors Insurance when they make a decision whether a specific disability applicant will or will not be accepted for rehabilitation services. Such a report is prepared for all applicants who are referred for rehabilitation services, whether or not a claim of disability is allowed.

For individuals accepted for services, specific rehabilitation plans are developed to the extent possible. Upon completion of these plans—at the time individual cases are closed from the active rolls of the State vocational rehabilitation agencies—the agencies again report to the Bureau of Old-Age and Survivors Insurance indicating whether or not the individual was successfully rehabilitated. As in the case of the acceptance reports, the closure reports are also prepared for all applicants who were accepted for rehabilitation services, whether or not the disability claim was allowed.

These tables contain data on the extent to which OASI disability applicants, accepted for services, were successfully rehabilitated—i.e., returned to productive employment. Data on the extent to which disability applicants referred to State vocational rehabilitation agencies by the Bureau of Old-Age and Survivors Insurance were accepted for services is presented in the following section. The tables pertain to persons applying both as disabled workers and for childhood disability benefits. Since the character of childhood disability cases differs considerably from that of disabled workers, the data are presented separately. These tables also pertain to all disability applicants including both those allowed and denied a period of disability. The data are based on about 10,300 case closure reports (form OA-D853c) received from State rehabilitation agencies by the Bureau of Old-Age and Survivors Insurance from the beginning of the OASI vocational rehabilitation referral program through the end of April 1959. The Bureau states that the data reflect the fact that successful completion of a rehabilitation plan probably takes considerably longer than unsuccessful closure of a plan. Thus, the figures given here cannot be specifically related to disability claims or rehabilitation acceptances of any given period.

In reading the following material the Bureau points out that it must be borne in mind that the rehabilitation agencies receive referrals from many agencies other than the Bureau and while the State agencies endeavor to provide services to as many disabled people as possible, including OASI referrals, reemployment is the chief goal so those persons offering the greatest potential in this respect will naturally receive first consideration. Moreover, since the disability program has been in operation a relatively short time, the number of applicants considered for rehabilitation and not carried through to successful rehabilitation would be abnormally high during the first years. This is due, the Bureau states, to the fact that many of the early applicants had severe disabilities of a number of years' duration which coupled with advanced age made them at best dubious prospects for rehabilitation. Applicants whose onset of disability is more recent generally offer greater potential for rehabilitation.

Some highlights

A. Rate of rehabilitation—The overall picture

1. Overall, slightly more than one out of four of the closed disability freeze and benefit cases were rehabilitated successfully (table U).
2. The rate of rehabilitation for childhood disability applicants was slightly lower than that for workers. Somewhat less than one out of four of the closed "children's" cases were rehabilitated. The difference in rate is especially marked when comparisons are made for specific age groups (table U).

B. The factors of age and recency of onset of disability

1. The likelihood of successful rehabilitation is strongly related to the age of the applicant. Since age is correlated with other characteristics—such as nature and severity of impairment, and education—the data do not reflect the effects of age alone on rehabilitation. Nevertheless, it is significant to note that the proportion of persons actually rehabilitated varied inversely with age. For disability freeze and benefit cases, the proportion of successful rehabilitants ranged from more than half of those under 35 to less than 1 out of 5 of those aged 60 and over. For persons aged 50–64, inclusive, about one out of five were successfully rehabilitated (table U).

2. For childhood disability cases, also, the rate of rehabilitation varied inversely with age. For “children” under age 25, almost 4 out of 10 were rehabilitated. The rate fell off rapidly with advancing age so that only one out of seven of those aged 35–39 were reported as rehabilitated (table U).

3. There also appeared to be a relationship between the recency of the onset of the disability and the rehabilitation rate, with the more recent onsets being rehabilitated at a somewhat higher rate. About one out of three disability freeze and benefit applicants who allegedly became disabled in 1955 or 1954 were successfully rehabilitated compared with one out of six of those with onsets in 1949 or prior. The lower rehabilitation rate for persons with 1958–56 onsets compared with the rate for persons with 1955–54 onsets probably reflects the fact that the data for the persons with onsets in 1958–56, inclusive, are likely to be based on “early returns.” The rehabilitation rate for these people is, therefore, likely to be understated since unsuccessful closures tend to be received earlier than successful closures (table V).

4. As with initial acceptance rates, age seemed to be a more important determinant than onset of disability as far as successful rehabilitation is concerned. Rehabilitation rates varied more by age than they did by year of onset of disability (table V).

C. Individual State differences

For disability freeze and benefit cases, rehabilitation rates ranged from 4.4 percent (1 out of 25) to 68.5 percent (almost 7 out of 10). In 12 States (out of 36 for which reliable rates could be computed), one-half or more of the closed cases were successfully rehabilitated. In 12 other States, rehabilitation rates ranged from 25 to 49 percent, inclusive (table W). State variations may result, in part, from the fact that some States undertake more vigorous selection devices than others, thus accepting for services persons who are more likely to be successfully rehabilitated.

TABLE U.—OASI vocational rehabilitation referral program: Number of disability applicant cases closed from State rehabilitation agency rolls to date and number and percent successfully rehabilitated by age and type of application ¹

Age ²	Disabled worker cases			Childhood disability cases		
	Total closed cases	Successfully rehabilitated		Total closed cases	Successfully rehabilitated	
		Number	Percent of total		Number	Percent of total
Total.....	9, 832	2, 647	26. 9	465	113	24. 3
Under 25.....	47	14	(³)	146	56	38. 4
25 to 29.....	144	76	52. 8	65	19	29. 3
30 to 34.....	296	158	53. 4	61	12	19. 7
35 to 39.....	500	243	48. 6	70	10	14. 3
40 to 44.....	725	313	43. 2	48	4	(³)
45 to 49.....	1, 077	378	35. 1	27	5	(³)
50 to 54.....	2, 213	491	22. 2	14	2	(³)
55 to 59.....	2, 489	518	20. 8	4	1	(³)
60 to 64.....	1, 704	338	19. 8	3	0	(³)
65 and over.....	311	55	17. 7	4	1	(³)
Unknown.....	326	63	19. 3	23	3	(³)

¹ Based on cumulative number of case closure reports (853c) received by Bureau of Old-Age and Survivors Insurance from State vocational rehabilitation agencies through April 1959.

² Age on birthday in year of final action by State vocational rehabilitation agency.

³ Number of cases too small for reliable computation.

TABLE V.—OASI vocational rehabilitation referral program: Number of disability freeze and benefit applicants closed from State rehabilitation agency rolls to date and number and percent rehabilitated by age and year of onset of disability¹

Year of onset of disability	All cases		Under 40 ²		40 to 49 ²	
	Total closed cases	Successfully rehabilitated		Total closed cases	Successfully rehabilitated	
		Number	Percent of total		Number	Percent of total
Total.....	9,832	2,647	26.9	987	691	38.3
1958-56.....	2,517	614	24.4	223	155	37.5
1955-54.....	3,460	1,130	32.7	417	308	44.8
1953-52.....	1,719	451	26.2	161	116	34.2
1951-50.....	771	176	22.8	64	51	34.5
1949 and prior.....	1,149	205	17.8	102	48	25.5
Unknown.....	216	71	32.9	20	13	(³)

Year of onset of disability	50 to 64 ²			65 and over ²			Unknown		
	Total closed cases	Successfully rehabilitated		Total closed cases	Successfully rehabilitated		Total closed cases	Successfully rehabilitated	
		Number	Percent of total		Number	Percent of total		Number	Percent of total
Total.....	6, 406	1, 347	21. 0	311	55	17. 7	326	63	19. 3
1958-56.....	1, 753	325	18. 5	26	9	(³)	102	10	9. 8
1955-54.....	2, 211	570	25. 8	96	19	19. 8	49	5	(³)
1953-52.....	1, 125	236	21. 0	70	15	21. 4	24	8	(³)
1951-50.....	505	89	17. 6	37	4	(³)	17	1	(³)
1949 and prior.....	752	114	15. 2	79	7	8. 9	28	5	(³)
Unknown.....	60	13	21. 7	3	1	(³)	106	34	32. 1

¹ Based on cumulative number of case closure reports (853c) received by Bureau of Old-Age and Survivors Insurance from State vocational rehabilitation agencies through April 1959.

² Age on birthday in year of final action by State vocational rehabilitation agency.

³ Number of cases too small for reliable computation.

TABLE W.—OASI vocational rehabilitation referral program: Number of disability applicant cases closed from State rehabilitation agency rolls to date and number and percent successfully rehabilitated by State and type of application ¹

State	Disability freeze and benefit cases			Childhood disability cases		
	Total closed cases	Successfully rehabilitated		Total closed cases	Successfully rehabilitated	
		Number	Percent of total		Number	Percent of total
Total.....	9, 832	2, 647	26. 9	465	113	24. 3
Alabama.....	49	32	(²)	3	2	(²)
Alaska.....	7	3	(²)	(³)	(³)	(³)
Arizona.....	66	36	54. 5	3	2	(²)
Arkansas.....	15	8	(²)	(³)	(³)	(³)
California.....	288	82	28. 5	10	2	(²)
Colorado.....	82	42	51. 2	6	4	(²)
Connecticut.....	145	72	49. 7	6	4	(²)
Delaware.....	26	21	(²)	(³)	(³)	(³)
District of Columbia.....	24	14	(²)	2	0	(²)
Florida.....	348	176	50. 6	14	4	(²)
Georgia.....	256	102	39. 8	8	2	(²)
Hawaii.....	128	29	22. 7	1	0	(²)
Idaho.....	197	14	7. 1	11	0	(²)
Illinois.....	298	145	48. 7	18	8	(²)
Indiana.....	86	50	58. 1	3	3	(²)
Iowa.....	191	125	65. 4	6	5	(²)
Kansas.....	80	40	50. 0	2	1	(²)
Kentucky.....	22	13	(²)	1	1	(²)
Louisiana.....	77	43	55. 8	(³)	(³)	(³)
Maine.....	102	18	17. 6	5	0	(²)
Maryland.....	46	28	(²)	3	0	(²)
Massachusetts.....	145	53	36. 6	6	3	(²)
Michigan.....	459	118	25. 7	24	7	(²)
Minnesota.....	36	21	(²)	1	1	(²)
Mississippi.....	114	18	15. 8	5	1	(²)
Missouri.....	104	58	55. 8	6	3	(²)
Montana.....	6	3	(²)	(³)	(³)	(³)
Nebraska.....	85	46	54. 1	5	1	(²)
Nevada.....	5	4	(²)	(³)	(³)	(³)
New Hampshire.....	45	7	(²)	2	2	(²)
New Jersey.....	534	88	16. 5	28	5	(²)
New Mexico.....	15	10	(²)	1	1	(²)
New York.....	423	158	37. 4	23	8	(²)
North Carolina.....	61	38	62. 3	6	4	(²)
North Dakota.....	58	10	17. 2	1	0	(²)
Ohio.....	278	75	27. 0	11	1	(²)
Oklahoma.....	403	59	14. 6	16	4	(²)
Oregon.....	279	41	14. 7	9	0	(²)
Pennsylvania.....	810	146	18. 0	54	10	18. 5

See footnotes at end of table, p. 133.

TABLE W.—OASI vocational rehabilitation referral program: Number of disability applicant cases closed from State rehabilitation agency rolls to date and number and percent successfully rehabilitated by State and type of application ¹—Continued

State	Disability freeze and benefit cases			Childhood disability cases		
	Total closed cases	Successfully rehabilitated		Total closed cases	Successfully rehabilitated	
		Number	Percent of total		Number	Percent of total
Puerto Rico.....	4	1	(²)	1	0	(²)
Rhode Island.....	112	32	28.6	10	6	(²)
South Carolina.....	377	54	14.3	22	1	(²)
South Dakota.....	28	0	(²)	2	0	(²)
Tennessee.....	1,814	80	4.4	93	3	3.2
Texas.....	108	74	68.5	2	0	(²)
Utah.....	24	10	(²)	1	1	(²)
Vermont.....	112	10	8.9	2	0	(²)
Virginia.....	76	32	42.1	3	2	(²)
Washington.....	270	101	37.4	5	3	(²)
West Virginia.....	306	84	27.5	18	2	(²)
Wisconsin.....	180	119	66.1	5	5	(²)
Wyoming.....	28	4	(²)	1	1	(²)

¹ Based on cumulative number of case closure reports (853c) received by Bureau of Old-Age and Survivors Insurance from State vocational rehabilitation agencies through April 1959.

² Number of cases too small for reliable computation.

³ No reports received.

TABLE X.—OASI vocational rehabilitation referral program: Number of disability freeze and benefit cases closed from State rehabilitation agency rolls to date and number and percent successfully rehabilitated by State and age¹

State	Age ² and results of rehabilitation services														
	All cases			Under 50			50 to 64			65 and over			Unknown		
	Total closed cases	Successfully rehabilitated		Total closed cases	Successfully rehabilitated		Total closed cases	Successfully rehabilitated		Total closed cases	Successfully rehabilitated		Total closed cases	Successfully rehabilitated	
		Num-ber	Percent of total		Num-ber	Percent of total		Num-ber	Percent of total		Num-ber	Percent of total		Num-ber	Percent of total
Total-----	9, 832	2, 647	26. 9	2, 789	1, 182	42. 4	6, 406	1, 347	21. 0	311	55	17. 7	326	63	19. 3
Alabama-----	49	32	65. 3	14	10	(³)	32	21	(³)	1	0	(³)	2	1	(³)
Alaska-----	7	3	(³)	4	3	(³)	2	0	(³)	1	0	(³)	0	0	0
Arizona-----	66	36	54. 5	26	17	(³)	34	17	(³)	1	0	(³)	5	2	(³)
Arkansas-----	15	8	(³)	3	1	(³)	12	7	(³)	0	0	0	0	0	0
California-----	288	82	28. 5	114	47	41. 2	154	32	20. 8	1	0	(³)	19	3	(³)
Colorado-----	82	42	51. 2	34	21	(³)	43	20	(³)	2	0	(³)	3	1	(³)
Connecticut-----	145	72	49. 7	48	35	(³)	86	35	40. 7	5	0	(³)	6	2	(³)
Delaware-----	26	21	(³)	5	4	(³)	17	14	(³)	1	1	(³)	3	2	(³)
District of Columbia-----	24	14	(³)	13	7	(³)	10	7	(³)	0	0	0	1	0	(³)
Florida-----	348	176	50. 6	106	63	59. 4	222	101	45. 5	11	8	(³)	9	4	(³)
Georgia-----	256	102	39. 8	74	37	50. 0	161	59	36. 6	9	2	(³)	12	4	(³)
Hawaii-----	128	29	22. 7	29	12	(³)	96	16	16. 7	0	0	0	3	1	(³)
Idaho-----	197	14	7. 1	61	10	16. 4	129	4	3. 1	0	0	0	7	0	(³)
Illinois-----	298	145	48. 7	120	71	59. 2	164	71	43. 3	3	2	(³)	11	1	(³)
Indiana-----	86	50	58. 1	39	25	(³)	43	24	(³)	4	1	(³)	0	0	0
Iowa-----	191	125	65. 4	75	50	66. 7	108	71	65. 7	5	2	(³)	3	2	(³)
Kansas-----	80	40	50. 0	24	14	(³)	50	25	50. 0	4	0	(³)	2	1	(³)

Kentucky-----	22	13	(3)	11	8	(3)	9	4	(3)	0	0	0	2	1	(3)
Louisiana-----	77	43	55.8	36	23	(3)	41	20	(3)	0	0	0	0	0	0
Maine-----	102	18	17.6	19	4	(3)	66	12	18.2	16	1	(3)	1	1	(3)
Maryland-----	46	28	(3)	27	19	(3)	19	9	(3)	0	0	0	0	0	0
Massachusetts-----	145	53	36.6	53	28	52.8	76	23	30.3	5	1	(3)	11	1	(3)
Michigan-----	459	118	25.7	137	58	42.3	302	58	19.2	11	2	(3)	9	0	(3)
Minnesota-----	36	21	(3)	13	9	(3)	22	12	(3)	0	0	0	1	0	(3)
Mississippi-----	114	18	15.8	20	7	(3)	81	10	12.3	10	1	(3)	3	0	(3)
Missouri-----	104	58	55.8	37	24	(3)	61	32	52.5	2	0	(3)	4	2	(3)
Montana-----	6	3	(3)	3	3	(3)	3	0	(3)	0	0	0	0	0	0
Nebraska-----	85	46	54.1	25	18	(3)	53	24	45.3	5	3	(3)	2	1	(3)
Nevada-----	5	4	(3)	5	4	(3)	0	0	0	0	0	0	0	0	0
New Hampshire-----	45	7	(3)	8	2	(3)	36	5	(3)	1	0	(3)	0	0	0
New Jersey-----	534	88	16.5	134	29	21.6	376	52	13.8	13	4	(3)	11	3	(3)
New Mexico-----	15	10	(3)	2	0	(3)	12	10	(3)	0	0	0	1	1	(3)
New York-----	423	158	37.4	130	66	50.8	269	86	32.0	19	4	(3)	5	2	(3)
North Carolina-----	61	38	62.3	21	16	(3)	36	21	(3)	3	0	(3)	1	1	(3)
North Dakota-----	58	10	17.2	20	6	(3)	36	4	(3)	2	0	(3)	0	0	0
Ohio-----	278	75	27.0	93	31	33.3	170	40	23.5	3	0	(3)	12	4	(3)
Oklahoma-----	403	59	14.6	63	21	33.3	282	34	12.1	6	2	(3)	52	2	3.8
Oregon-----	279	41	14.7	93	23	24.7	178	16	9.0	2	0	(3)	6	2	(3)
Pennsylvania-----	810	146	18.0	175	69	39.4	519	73	14.1	81	2	2.5	35	2	(3)
Puerto Rico-----	4	1	(3)	0	0	0	2	1	(3)	0	0	0	2	0	(3)
Rhode Island-----	112	32	28.6	41	15	(3)	66	15	22.7	2	1	(3)	3	1	(3)
South Carolina-----	377	54	14.3	85	29	34.1	282	24	8.5	8	0	(3)	2	1	(3)
South Dakota-----	28	0	(3)	1	0	(3)	23	0	(3)	3	0	(3)	1	0	(3)
Tennessee-----	1,814	80	4.4	349	38	10.9	1,418	39	2.8	25	2	(3)	22	1	(3)
Texas-----	108	74	68.5	44	35	(3)	61	37	60.7	2	2	(3)	1	0	(3)
Utah-----	24	10	(3)	7	3	(3)	15	7	(3)	2	0	(3)	0	0	0
Vermont-----	112	10	8.9	18	2	(3)	78	7	9.0	11	1	(3)	5	0	(3)

See footnotes at end of table, p. 136.

TABLE X.—OASI vocational rehabilitation referral program: Number of disability freeze and benefit cases closed from State rehabilitation agency rolls to date and number and percent successfully rehabilitated by State and age ¹—Continued

State	Age ² and results of rehabilitation services														
	All cases			Under 50			50 to 64			65 and over			Unknown		
	Total closed cases	Successfully rehabilitated		Total closed cases	Successfully rehabilitated		Total closed cases	Successfully rehabilitated		Total closed cases	Successfully rehabilitated		Total closed cases	Successfully rehabilitated	
		Num-ber	Percent of total		Num-ber	Percent of total		Num-ber	Percent of total		Num-ber	Percent of total		Num-ber	Percent of total
Virginia-----	76	32	42.1	27	9	(³)	41	20	(³)	3	1	(³)	5	2	(³)
Washington-----	270	101	37.4	110	56	50.9	126	39	31.0	6	1	(³)	28	5	(³)
West Virginia-----	306	84	27.5	107	41	38.3	181	38	21.0	9	1	(³)	9	4	(³)
Wisconsin-----	180	119	66.1	81	57	70.4	82	49	59.8	11	10	(³)	6	3	(³)
Wyoming-----	28	4	(³)	5	2	(³)	21	2	(³)	2	0	(³)	0	0	0

¹ Based on cumulative number of case closure reports (853c) received by Bureau of Old-Age and Survivors Insurance from State vocational rehabilitation agencies through April 1959.

² Age on birthday in year of final action by State vocational rehabilitation agency.

³ Number of cases too small for reliable computation.

DISABILITY APPLICANTS CONSIDERED FOR SERVICES BY STATE AGENCIES

General

The following five tables contain selected data on the operation of the OASI vocational rehabilitation referral program. Under this program, all disability applicants—including applicants for the disability freeze, for disability insurance benefits and for childhood disability benefits—and many persons who inquire about the disability program but do not apply are referred to State vocational rehabilitation agencies for consideration for rehabilitation services. The State vocational rehabilitation agencies report to the Bureau of Old-Age and Survivors Insurance their decision as to the acceptance for services of each disability applicant who is considered. Subsequent to acceptance for services the potential rehabilitant is further considered in the State vocational rehabilitation agency with regard to the specific rehabilitation plan suited to his case, and not infrequently it is found that no such plan can be developed. The tabulations presented here include only the reports, as originally received, of cases accepted for services. These data apply to all referrals and do not differentiate the results achieved for those applicants whose OASI disability claims were allowed from those whose claims were denied. The Bureau states that from sample studies it appears that the acceptance rate for the latter, generally speaking less severely disabled applicants, is about double the rate for allowed applicants.

The tables included are based on about 296,000 case disposition reports on some 271,000 applicants for the disability freeze and disability benefits—generally persons who were applying for protection based on their having worked in covered employment—and 25,000 reports on childhood disability applicants whose application for benefits is based on possible eligibility flowing from a deceased or retired parent who had earned old-age and survivors insurance protection. Childhood disability benefits are payable only to persons whose disabilities began before the age of 18. Most childhood disability applicants became disabled at or soon after birth. Thus, the nature of the childhood disability cases differs considerably from that of disabled workers and the data are presented separately.

*Some highlights**A. Rate of acceptance—the overall picture*

1. Fewer than 1 in 20 of the disability applicants considered for services were accepted by the State vocational rehabilitation agencies (tables Y and Z).

2. The overall rate of acceptance was substantially less for women than for men with the rate for men approaching the 1 out of 20 level while the rate for women was less than 1 out of 25 (tables Y and Z).

3. Childhood disability applicants had a lower acceptance rate than did the worker applicants. The difference in rate is especially marked when comparisons are made for specific age groups (tables Y and Z).

B. The factors of age and recency of onset of disability

1. The likelihood of acceptance for rehabilitation is very strongly related to the age of the applicant. Of course, age is correlated with other characteristics, especially nature and severity of impairment so that the data do not reflect the effects of age alone on rehabilitation. Nevertheless, it is significant to note that the rate of acceptance varied

inversely with age. For disabled workers the rate ranged from 11 percent of those under 30 to 0.5 percent of those aged 65 and over. For those aged 50-64, less than 1 out of 25 were accepted for services (table Y).

2. For childhood disability applicants, only those under the age of 30 appeared to have a rehabilitation potential of some proportion. Among the males in this age group about 1 out of 12 were accepted but the potential fell off so rapidly by age that only 1 in 33 of the males 30-34 were accepted (table Z).

3. The recency of the onset of the disability—in other words, the promptness of referral—was also correlated with the acceptance rate, with the more recent onsets being accepted at a somewhat higher rate. About 1 out of 20 of the disability freeze and benefit applicants who alleged that they became disabled in 1956 or 1955 were accepted for services compared to 1 out of 30 of those who became disabled in 1952 or prior (table AA).

4. The fact that the rate of acceptance for 1958-57 onsets was lower than that for 1956-55 onsets was due to differences in age of the two groups. In the attached tables, the persons with onsets in 1958-57 were older than those with 1956-55 onsets (table AA).

5. Age seemed to be a far more important variable than onset of disability as far as acceptance for rehabilitation services is concerned. Acceptance rates varied more by age than they did by onset of disability (table AA).

6. The highest acceptance rate shown by the data was 12.9 for disability freeze and benefit applicants under age 35 with onsets in 1958 or 1957. Even this rate represented only one out of eight applicants in this group who were considered for services (table AA).

C. Individual State differences

1. For disability freeze and benefit applicants, the rate of acceptance among individual States ranged from 1.1 percent (1 out of 100) to 40 percent (4 out of 10). Only seven States accepted as many as 10 percent of those considered for services (table AB).

2. For childhood disability cases, acceptance rates ranged from 1.3 percent (1 out of 100) to 23.1 percent (1 out of 4) among individual States. Only six States accepted as many as 10 percent of those considered for services (table AB).

3. For all individual States, acceptance rates also varied with age. For disability freeze and benefit applicants under age 50, acceptance rates in individual States ranged from 2.5 percent to 50.5 percent. In nine States, about one-fourth or more of those under age 50 considered for services were accepted. For persons aged 50-64, acceptance rates ranged from 0.6 percent to 39.6 percent. Only seven States accepted one-tenth or more of the persons in this age group whom they considered (table AC).

TABLE Y.—*OASI vocational rehabilitation referral program: Disability freeze and benefit applicants considered for rehabilitation services and number and percent accepted for services by age and sex, 1958*¹

Age ²	Total			Male			Female		
	Total	Accepted for services		Total	Accepted for services		Total	Accepted for services	
		Number	Percent of total		Number	Percent of total		Number	Percent of total
Total.....	270,903	12,465	4.6	211,390	10,256	4.9	59,513	2,209	3.7
Under 30.....	3,873	432	11.2	3,135	360	11.5	738	72	9.8
30 to 34.....	6,447	603	9.4	5,131	517	10.1	1,316	86	6.5
35 to 39.....	9,358	879	9.4	7,433	742	10.0	1,925	137	7.1
40 to 44.....	13,165	1,246	9.5	10,159	1,059	10.4	3,006	187	6.2
45 to 49.....	20,283	1,724	8.5	14,926	1,429	9.6	5,357	295	5.5
50 to 54.....	45,611	3,161	6.9	32,163	2,470	7.7	13,448	691	5.1
55 to 59.....	61,886	2,588	4.2	44,859	2,094	4.7	17,027	494	2.9
60 to 64.....	79,469	948	1.2	67,889	840	1.2	11,580	108	.9
65 and over.....	9,211	43	.5	8,413	41	.5	798	2	.3
Unknown.....	21,600	841	3.9	17,282	704	4.1	4,318	137	3.2

¹ Based on case disposition reports (853b's) received by Bureau of Old-Age and Survivors Insurance from State vocational rehabilitation agencies during 1958.

² Age on birthday in year of referral for rehabilitation services.

TABLE AB.—OASI vocational rehabilitation referral program: Disability applicants considered for rehabilitation services and number and percent accepted for services by State and type of application, 1958 ¹

State	Disability freeze and benefit cases			Childhood disability cases		
	Total	Accepted for services		Total	Accepted for services	
		Number	Percent of total		Number	Percent of total
Total.....	270, 903	12, 465	4. 6	25, 329	1, 011	4. 0
Alabama.....	5, 345	305	5. 7	552	37	6. 7
Alaska.....	93	6	6. 5	4	1	(²)
Arizona.....	1, 719	50	2. 9	77	6	7. 8
Arkansas.....	2, 387	103	4. 3	273	4	1. 5
California.....	20, 272	524	2. 6	1, 037	26	2. 5
Colorado.....	2, 193	170	7. 8	134	8	6. 0
Connecticut.....	3, 772	148	3. 9	367	11	3. 0
Delaware.....	621	39	6. 3	46	3	(²)
District of Columbia.....	1, 633	92	5. 6	50	6	12. 0
Florida.....	9, 283	531	5. 7	406	35	8. 6
Georgia.....	6, 767	490	7. 2	447	13	2. 9
Hawaii.....	781	48	6. 1	46	6	(²)
Idaho.....	535	146	27. 3	65	15	23. 1
Illinois.....	14, 253	660	4. 6	1, 425	53	3. 7
Indiana.....	7, 058	76	1. 1	699	11	1. 6
Iowa.....	3, 440	193	5. 6	406	16	3. 9
Kansas.....	2, 717	72	2. 6	336	17	5. 1
Kentucky.....	6, 503	79	1. 2	541	15	2. 8
Louisiana.....	4, 661	201	4. 3	273	21	7. 7
Maine.....	1, 437	47	3. 3	174	6	3. 4
Maryland.....	4, 376	144	3. 3	331	13	3. 9
Massachusetts.....	12, 170	237	1. 9	1, 069	21	2. 0
Michigan.....	10, 132	422	4. 2	830	50	6. 0
Minnesota.....	2, 910	56	1. 9	452	9	2. 0
Mississippi.....	3, 013	80	2. 7	385	15	3. 9
Missouri.....	6, 746	117	1. 7	599	11	1. 8
Montana.....	826	38	4. 6	49	4	(²)
Nebraska.....	1, 379	120	8. 7	244	14	5. 7
Nevada.....	440	8	1. 8	19	2	(²)
New Hampshire.....	845	141	16. 7	81	10	12. 3
New Jersey.....	8, 040	285	3. 5	832	20	2. 4
New Mexico.....	855	32	2. 7	69	1	1. 4
New York.....	21, 556	410	1. 9	2, 115	28	1. 3
North Carolina.....	6, 282	245	3. 9	951	28	2. 9
North Dakota.....	315	24	7. 6	128	9	7. 0
Ohio.....	16, 170	278	1. 7	1, 325	33	2. 5
Oklahoma.....	2, 753	484	17. 6	238	25	10. 5
Oregon.....	2, 560	215	8. 4	158	5	3. 2
Pennsylvania.....	26, 778	843	3. 1	3, 124	93	3. 0
Puerto Rico.....	555	33	5. 9	281	12	4. 3

See footnotes at end of table, p. 144.

TABLE AB.—OASI vocational rehabilitation referral program: Disability applicants considered for rehabilitation services and number and percent accepted for services by State and type of application, 1958 ¹—Continued

State	Disability freeze and benefit cases			Childhood disability cases		
	Total	Accepted for services		Total	Accepted for services	
		Number	Percent of total		Number	Percent of total
Rhode Island.....	1, 401	189	13. 5	93	5	5. 4
South Carolina.....	4, 494	159	3. 5	374	7	1. 9
South Dakota.....	548	55	10. 0	113	9	8. 0
Tennessee.....	6, 157	2, 464	40. 0	618	130	21. 0
Texas.....	12, 370	224	1. 8	1, 003	23	2. 3
Utah.....	748	27	3. 6	127	3	2. 4
Vermont.....	701	116	16. 5	82	15	18. 3
Virginia.....	6, 792	272	4. 0	699	22	3. 1
Washington.....	3, 713	167	4. 5	223	9	4. 0
West Virginia.....	4, 430	345	7. 8	559	41	7. 3
Wisconsin.....	4, 985	235	4. 7	767	32	4. 2
Wyoming.....	393	29	7. 4	33	2	(²)

¹ Based on case disposition reports (853b's) received by Bureau of Old-Age and Survivors Insurance from State vocational rehabilitation agencies during 1958.

² Number of cases too small for reliable computation.

TABLE AC.—OASI vocational rehabilitation referral program: Disability freeze and benefit applicants considered for rehabilitation services and number and percent accepted for services by State and age, 1958¹

State	Age 2 and disposition											
	Under 50			50-64		65 and over		Unknown				
	Total	Accepted for services		Total	Accepted for services		Total	Accepted for services		Total		
		Number	Percent of total		Number	Percent of total		Number	Percent of total		Number	Percent of total
Total-----	53, 125	4, 883	9. 2	186, 967	6, 698	3. 6	9, 211	43	0. 5	21, 600	841	3. 9
Alabama-----	1, 016	135	13. 3	3, 890	156	4. 0	124	0	0	315	14	4. 4
Alaska-----	11	3	(3)	75	3	4. 0	5	0	(3)	2	0	(3)
Arizona-----	301	22	7. 3	1, 245	22	1. 8	50	1	2. 0	123	5	4. 1
Arkansas-----	453	39	8. 6	1, 709	63	3. 7	70	0	0	155	1	. 6
California-----	3, 815	215	5. 6	14, 010	258	1. 8	787	0	0	1, 660	51	3. 1
Colorado-----	359	83	23. 1	1, 627	80	4. 9	80	0	0	127	7	5. 5
Connecticut-----	704	57	8. 1	2, 621	76	2. 9	169	1	. 6	278	14	5. 0
Delaware-----	103	12	11. 7	461	25	5. 4	20	0	(3)	37	2	(3)
District of Columbia-----	374	43	11. 5	1, 068	41	3. 8	79	0	0	112	8	7. 1
Florida-----	1, 475	219	14. 8	6, 907	288	4. 2	327	3	. 9	574	21	3. 7
Georgia-----	1, 678	202	12. 0	4, 579	266	5. 8	157	4	2. 5	353	18	5. 1
Hawaii-----	251	30	12. 0	468	17	3. 6	30	0	(3)	32	1	(3)
Idaho-----	91	46	50. 5	374	80	21. 4	19	0	(3)	51	20	39. 2
Illinois-----	3, 684	319	8. 7	9, 091	282	3. 1	402	6	1. 5	1, 076	53	4. 9
Indiana-----	1, 761	44	2. 5	4, 686	29	. 6	196	1	. 5	415	2	. 5
Iowa-----	535	80	15. 0	2, 430	95	3. 9	109	0	0	366	18	4. 9

See footnotes at end of table, p. 147.

TABLE AC.—OASI vocational rehabilitation referral program: Disability freeze and benefit applicants considered for rehabilitation services and number and percent accepted for services by State and age, 1958¹—Continued

State	Age ² and disposition											
	Under 50			50-64			65 and over			Unknown		
	Total	Accepted for services		Total	Accepted for services		Total	Accepted for services		Total	Accepted for services	
		Number	Percent of total		Number	Percent of total		Num-ber	Percent of total			Num-ber
Kansas-----	492	27	5.5	1,921	43	2.2	98	1	1.0	206	1	0.5
Kentucky-----	1,307	42	3.2	4,430	31	.7	107	0	0	659	6	.9
Louisiana-----	746	105	14.1	3,545	92	2.6	139	0	0	231	4	1.7
Maine-----	308	27	8.8	897	14	1.6	48	0	(³)	184	6	3.3
Maryland-----	894	78	8.7	2,993	47	1.6	107	0	0	382	19	5.0
Massachusetts-----	2,133	116	5.4	8,544	97	1.1	448	0	0	1,045	24	2.3
Michigan-----	2,196	190	8.7	6,899	168	2.4	208	0	0	829	64	7.7
Minnesota-----	504	26	5.2	1,999	20	1.0	114	0	0	293	10	3.4
Mississippi-----	538	29	5.4	2,202	49	2.2	73	0	0	200	2	1.0
Missouri-----	1,141	46	4.0	4,982	65	1.3	260	0	0	363	6	1.7
Montana-----	125	23	18.4	595	11	1.8	37	0	(³)	69	4	5.8
Nebraska-----	223	45	20.2	978	62	6.3	51	0	0	127	13	10.2
Nevada-----	42	1	(³)	360	5	1.4	14	0	(³)	24	2	(³)
New Hampshire-----	111	29	26.1	663	103	15.5	26	1	(³)	45	8	(³)
New Jersey-----	1,842	84	4.6	4,392	140	3.2	299	0	0	1,507	61	4.0
New Mexico-----	163	11	6.7	615	12	2.0	27	0	(³)	50	0	0
New York-----	4,365	189	4.3	14,164	184	1.3	1,006	5	.5	2,021	32	1.6
North Carolina-----	1,487	99	6.7	4,136	130	3.1	149	1	.7	510	15	2.9
North Dakota-----	51	13	25.5	221	10	4.5	15	0	(³)	28	1	(³)

Ohio-----	2, 834	134	4. 7	11, 454	121	1. 1	650	2	. 3	1, 232	21	1. 7
Oklahoma-----	473	144	30. 4	1, 949	307	15. 8	90	0	0	241	33	13. 7
Oregon-----	473	109	23. 0	1, 805	96	5. 3	109	1	. 9	173	9	5. 2
Pennsylvania-----	4, 361	326	7. 5	19, 363	462	2. 4	1, 127	5	. 4	1, 927	50	2. 6
Puerto Rico-----	120	8	6. 7	379	17	4. 5	10	0	(3)	46	8	(3)
Rhode Island-----	311	77	24. 8	975	102	10. 5	41	0	(3)	74	10	13. 5
South Carolina-----	1, 063	90	8. 5	3, 083	63	2. 0	102	0	0	246	6	2. 4
South Dakota-----	79	9	11. 4	389	40	10. 3	19	0	(3)	61	6	9. 8
Tennessee-----	1, 188	581	48. 9	4, 559	1, 804	39. 6	125	7	5. 6	285	72	25. 3
Texas-----	2, 585	143	5. 5	8, 684	68	. 8	287	1	. 3	814	12	1. 5
Utah-----	100	12	12. 0	519	6	1. 2	48	0	(3)	81	9	11. 1
Vermont-----	125	41	32. 8	460	61	13. 3	25	0	(3)	91	14	15. 4
Virginia-----	1, 648	134	8. 1	4, 249	116	2. 7	161	1	. 6	734	21	2. 9
Washington-----	857	100	11. 7	2, 296	52	2. 3	136	0	0	424	15	3. 5
West Virginia-----	725	120	16. 6	3, 110	197	6. 3	154	1	. 6	441	27	6. 1
Wisconsin-----	848	119	14. 0	3, 636	102	2. 8	263	1	. 4	238	13	5. 5
Wyoming-----	56	7	12. 5	280	20	7. 1	14	0	(3)	43	2	(3)

¹ Based on case disposition reports (853b's) received by Bureau of Old-Age and Survivors Insurance from State vocational rehabilitation agencies during 1958.

² Age on birthday in year of referral for rehabilitation services.

³ Number of cases too small for reliable computation.

SUMMARY OF SELECTED DATA ON DISABILITY OPERATIONS ¹

I. INITIAL APPLICATIONS: ALLOWANCES AND DENIALS

(Appeals on initial decisions of entitlement only—Hearing data based on records of Bureau of Old-Age and Survivors Insurance)

	<i>Cumulative through June 1959</i>	<i>Fiscal year 1959</i>	<i>April- June 1959</i>
A. Number of disability determinations-----	1, 168, 500	315, 600	91, 000
1. Disability insurance benefit-----	517, 600	218, 400	61, 200
2. Disability freeze-----	564, 100	64, 400	18, 300
3. Childhood disability-----	86, 800	32, 800	11, 500
B. Number of cases allowed-----	730, 600	202, 100	65, 500
1. Disability insurance benefit-----	312, 400	136, 100	43, 700
2. Disability freeze-----	341, 700	37, 700	11, 400
3. Childhood disability-----	76, 500	28, 300	10, 400
i. Allowed on initial determination-----	686, 500	183, 400	59, 000
1. Disability insurance benefit-----	290, 000	120, 900	38, 200
2. Disability freeze-----	321, 500	34, 900	10, 700
3. Childhood disability-----	75, 000	27, 600	10, 100
ii. Allowed on reconsideration and hearing--	44, 100	18, 700	6, 500
1. Disability insurance benefit-----	22, 400	15, 200	5, 500
2. Disability freeze-----	20, 200	2, 800	700
3. Childhood disability-----	1, 500	700	300
iii. Cases allowed as percent of disability determinations (item A)-----	63	64	72
1. Disability insurance benefit-----	60	62	71
2. Disability freeze-----	61	59	62
3. Childhood disability-----	88	86	90
C. Total number of determinations completed (by Bureau ² and States)-----	1, 490, 800	431, 000	123, 900
1. Disability insurance benefit-----	731, 000	304, 200	81, 000
2. Disability freeze-----	670, 100	93, 300	31, 100
3. Childhood disability-----	89, 700	33, 500	11, 800
D. Total number of cases denied (all reasons)--	760, 200	228, 900	58, 400
1. Disability insurance benefit-----	418, 600	168, 100	37, 300
2. Disability freeze-----	328, 400	55, 600	19, 700
3. Childhood disability-----	13, 200	5, 200	1, 400

See footnotes at end of table, p. 149.

I. INITIAL APPLICATIONS: ALLOWANCES AND DENIALS—continued

	<i>Cumulative through June 1959</i>	<i>Fiscal year 1959</i>	<i>April- June 1959</i>
D. Total number of cases denied—Continued			
i. Denied for failure to meet disability test..	437, 900	113, 500	25, 500
1. Disability insurance benefit.....	205, 200	82, 300	17, 500
2. Disability freeze.....	222, 400	26, 700	6, 900
3. Childhood disability.....	10, 300	4, 500	1, 100
ii. Denied for other reasons.....	322, 300	115, 400	32, 900
1. Disability insurance benefit.....	213, 400	85, 800	19, 800
2. Disability freeze.....	106, 000	28, 900	12, 800
3. Childhood disability.....	2, 900	700	300

¹ Disability insurance benefit applications were first taken October 1956. Prior to that date all applications were for the disability freeze. Of the close to ½ million applications filed before October 1956, about 6 out of 10 were filed by persons aged 50-64.

² Excludes some cases under special procedures where applicant filed formal application and he had no insured status at any time.

II. RECONSIDERATION AND HEARING CASES

A. Requests for reconsideration received.....	124, 900	41, 900	9, 100
1. Disability insurance benefit.....	65, 900	34, 700	7, 800
2. Disability freeze.....	55, 600	5, 900	1, 000
3. Childhood disability.....	3, 400	1, 300	300
B. Reconsideration determinations made.....	114, 000	42, 200	10, 700
1. Disability insurance benefit.....	56, 500	34, 500	9, 100
2. Disability freeze.....	54, 500	6, 400	1, 200
3. Childhood disability.....	3, 000	1, 300	400
i. Number allowed after reconsideration....	35, 700	15, 100	5, 100
1. Disability insurance benefit.....	19, 000	12, 500	4, 300
2. Disability freeze.....	15, 500	2, 100	600
3. Childhood disability.....	1, 200	500	200
ii. Percent of those reconsidered allowed after reconsideration.....	31	36	48
1. Disability insurance benefit.....	34	36	47
2. Disability freeze.....	28	33	50
3. Childhood disability.....	40	38	50

II. RECONSIDERATION AND HEARING CASES—continued

	<i>Cumulative through June 1959</i>	<i>Fiscal year 1959</i>	<i>April- June 1959</i>
C. Requests for hearing received-----	38, 300	17, 200	3, 300
1. Disability insurance benefit-----	22, 500	14, 400	2, 800
2. Disability freeze-----	14, 600	2, 300	400
3. Childhood disability-----	1, 200	500	100
D. Number of hearing cases in which action taken-----	28, 700	16, 300	5, 500
1. Disability insurance benefit-----	14, 500	11, 600	4, 500
2. Disability freeze-----	13, 400	4, 300	800
3. Childhood disability-----	800	400	200
i. Number of hearing cases allowed-----	8, 400	3, 600	1, 400
1. Disability insurance benefit-----	3, 400	2, 700	1, 200
2. Disability freeze-----	4, 700	700	200
3. Childhood disability-----	300	200	(¹)
(a) Cases allowed before hearing (after remand by referee)-----	6, 700	2, 200	700
1. Disability insurance benefit-----	2, 400	1, 700	600
2. Disability freeze-----	4, 100	400	100
3. Childhood disability-----	200	100	(¹)
(b) Cases allowed after hearing by referee-----	1, 700	1, 400	700
1. Disability insurance benefit-----	1, 000	1, 000	600
2. Disability freeze-----	600	300	100
3. Childhood disability-----	100	100	(¹)
ii. Hearing cases allowed as a percent of total actions taken-----	29	22	25
1. Disability insurance benefit-----	23	23	27
2. Disability freeze-----	35	16	25
3. Childhood disability-----	38	50	(¹)

¹ Less than 50 cases.

III. CONTINUING DISABILITY CASES

	<i>Cumulative through June 1959</i>	<i>Fiscal year 1959</i>	<i>April- June 1959</i>
A. Cases examined for possible issue of continuing disability	343, 800	185, 700	33, 200
B. Total number of cases disposed of	329, 600	182, 800	47, 000
i. Number of cases disposed of on basis of evidence in file	197, 000	98, 100	21, 500
ii. Number of cases disposed of after investigation	132, 600	84, 700	25, 500
1. Disability insurance benefit	91, 000	49, 900	15, 900
2. Disability freeze	40, 400	33, 700	9, 200
3. Childhood disability	1, 200	1, 100	400
iii. Number of cases terminated ¹	17, 900	10, 400	2, 900
1. Disability insurance benefit	7, 300	3, 800	700
2. Disability freeze	10, 500	6, 500	2, 200
3. Childhood disability	100	100	(²)
iv. Cases terminated as percent of total disposed of	5. 4	5. 7	6. 2
C. Number of reconsideration requests received	1, 600	1, 200	500
1. Disability insurance benefit	1, 400	1, 000	400
2. Disability freeze	200	200	100
3. Childhood disability	(²)	(²)	(²)
D. Number of reconsideration cases disposed of	1, 000	700	300
1. Disability insurance benefit	900	600	300
2. Disability freeze	100	100	(²)
3. Childhood disability	(²)	(²)	(²)
i. Number of terminations reversed after reconsideration	400	400	200
1. Disability insurance benefit	300	300	200
2. Disability freeze	100	100	(²)
3. Childhood disability	(²)	(²)	(²)
ii. Percent of those reconsidered allowed after reconsideration	40	³ 51	³ 60

¹ Refers to net number of cases terminated after adjustment for terminations reversed upon reconsideration. Figures exclude small number of hearing cases; experience too fragmentary to be significant.

² Less than 50 cases.

³ Computed on basis of unrounded figures.

IV. PENDING WORKLOADS (END OF JUNE 1959)

	<i>Total</i>	<i>DIB</i>	<i>Disability freeze</i>	<i>Child- hood disability</i>
A. Initial applications pending:				
i. At all stations.....	112,300	79,000	24,500	8,900
ii. In Bureau's district office.....	42,200	28,200	10,200	3,200
iii. In State agencies.....	53,700	39,000	9,900	4,900
iv. In Bureau's central office.....	16,400	11,800	3,800	800
B. Reconsideration requests pending initial decision of entitlement....				10,900
1. Disability insurance benefit.....				9,400
2. Disability freeze.....				1,100
3. Childhood disability.....				400
C. Reconsideration requests pending (continuing disability cases)....				600
1. Disability insurance benefit.....				500
2. Disability freeze.....				100
3. Childhood disability.....				(1)
D. Hearing requests pending (based on records of Bureau of Old Age and Survivors Insurance) ^{2 3}				9,600
1. Disability insurance benefit.....				8,000
2. Disability freeze.....				1,200
3. Childhood disability.....				400
E. Continuing disability cases pending.....				14,200
1. Disability insurance benefit.....				8,200
2. Disability freeze.....				5,900
3. Childhood disability.....				100

¹ Less than 50 cases.² Excludes about 100 pending requests for hearings on continuing disability cases.³ Figure shown is subject to adjustment on the basis of a periodic inventory which is now in process. When the inventory is completed, preliminary indications are that the pending will be reduced by several hundred while dispositions will be increased by the same number. The adjustment will affect fiscal years 1959 and 1958 and will, therefore, have little effect on any one year. The adjustment will apparently not affect the relationships shown by these figures between affirmations and reversals.

SUMMARY BENEFIT DATA
TABLE AD.—*Monthly data*

Type of benefit	Benefits awarded in June 1959		Benefits in current-payment status, end of June 1959			Amount of benefits paid ¹ April 1959 (in thousands)
	Number	Average amount	Number	Monthly rate (in thousands)	Average amount	
Total, OASI and DI ²	270, 341	-----	-----	-----	-----	\$848, 816
Total, OASI	242, 533	-----	-----	-----	-----	816, 871
Monthly benefits, OASI and DI	202, 224	-----	13, 181, 380	\$805, 545	-----	833, 861
Monthly benefits, OASI	174, 416	-----	12, 820, 164	778, 404	-----	801, 916
Monthly benefits, DI	27, 808	-----	361, 216	27, 141	-----	31, 945
Old-age (retired worker)	87, 879	\$80. 32	7, 295, 640	526, 701	\$72. 19	545, 394
Disability (disabled worker) ³	15, 729	91. 93	275, 164	24, 324	88. 40	28, 156
Wife's ⁴ or husband's (OASI and DI)	35, 508	39. 01	2, 141, 761	81, 295	37. 96	83, 015
Wife's or husband's (OASI)	30, 410	39. 21	2, 108, 534	80, 096	37. 99	81, 379
Wife's or husband's (DI)	5, 098	37. 79	33, 227	1, 199	36. 09	1, 636
Widow's or widower's	19, 350	60. 91	1, 321, 979	74, 359	56. 25	74, 623

See footnotes at end of table, p. 155.

TABLE AD.—*Monthly data—Continued*

Type of benefit	Benefits awarded in June 1959		Benefits in current-payment status, end of June 1959			Amount of benefits paid ¹ April 1959 (in thousands)
	Number	Average amount	Number	Monthly rate (in thousands)	Average amount	
Monthly benefits, OASI and DI—Continued						
Monthly benefits, DI—Continued						
Parent's.....	596	\$66.94	32,682	\$1,896	\$58.02	\$2,063
Child's (OASI and DI) ⁵	34,963	-----	1,747,656	76,209	-----	78,986
Child's (OASI—total).....	27,982	-----	1,694,831	74,591	-----	76,833
Child's (OASI—life) ⁶	6,972	29.56	231,766	6,208	26.78	5,916
Child's (OASI—survivor) ⁶	21,010	50.36	1,463,065	68,383	46.74	70,917
Child's (DI).....	6,981	32.06	52,825	1,618	30.62	2,153
Mother's.....	8,199	64.90	366,498	20,760	56.65	21,624
Lump-sum death payments.....	68,117	7 208.59	-----	-----	-----	14,955

FOOTNOTES

¹ Exceeds monthly amount of benefits in current-payment status because of the inclusion, in initial payments, of amounts payable for prior months. Distribution by type of monthly benefit estimated.

² Benefits under the old-age and survivors insurance (OASI) parts of the old-age, survivors, and disability insurance program are payable from the OASI trust fund to old-age insurance (retired worker) beneficiaries and their dependents and to survivors of deceased workers. Benefits under the disability insurance (DI) part of the program are payable from the DI trust fund to disability insurance (disabled worker) beneficiaries and their dependents. Monthly benefits were first payable to dependents of disability insurance (disabled worker) beneficiaries for the month of September 1958 and were first represented in October 1958 awards.

³ Payable to disabled workers aged 50 to 64. Effective for months beginning August 1958 disability insurance benefits are not offset by other benefits payable because of disability.

⁴ Includes, as a small proportion, wife beneficiaries under age 65

with child beneficiaries in their care. At the end of June 1959 there were an estimated 117,000 such benefits in current-payment status.

⁵ Includes benefits payable to disabled persons aged 18 or over—dependent children of disabled, deceased, or retired workers—whose disability began before age 18. At the end of June 1959 there were an estimated 58,000 such benefits in current-payment status.

⁶ Distribution by type of claim for OASI child's benefits estimated.

⁷ Average lump-sum per worker; there were 71,861 deceased workers represented in the current month's lump-sum awards.

Source: U.S. Department of Health, Education, and Welfare: Social Security Administration, Bureau of Old-Age and Survivors Insurance, Division of Program Analysis, Actuarial Branch.

TABLE AE.—*Fiscal year data*

Type of benefit	Benefits awarded July 1958-June 1959				Amount of benefits paid (in millions) ¹	
	Total number	At old benefit rates		At 1958 amendment benefit rates		July 1958- June 1959
		Number	Average amount	Number	Average amount	
Total, OASI and DI ²	3,038,093	-----	-----	-----	-----	\$9,388
Total, OASI	2,805,114	-----	-----	-----	-----	45,863
Monthly benefits, OASI and DI	2,281,075	864,961	-----	1,416,114	-----	9,049
Monthly benefits, OASI	2,048,096	785,683	-----	1,262,413	-----	9,239
Monthly benefits, DI	232,979	79,278	-----	153,701	-----	8,900
Old-age (retired worker)	1,047,105	406,483	\$75.20	640,622	\$81.16	339
Disability (disabled worker) ³	128,918	48,094	85.94	80,824	91.67	6,041
Wife's ⁴ or husband's (OASI and DI)	414,438	154,961	36.50	259,477	39.33	311
Wife's or husband's (OASI)	371,841	142,041	36.69	229,800	39.67	926
Wife's or husband's (DI)	42,597	12,920	34.38	29,677	36.75	913
Widow's or widower's	225,219	84,950	56.07	140,269	60.54	12
Parent's	6,075	1,586	62.28	4,489	67.57	833
Child's (OASI and DI) ⁵	368,065	133,584	39.06	234,481	42.66	22
Child's (OASI—total)	306,601	115,320	40.93	191,281	45.38	863
Child's (OASI—life) ⁶	73,143	25,340	25.55	47,803	29.94	847
Child's (OASI—Survivor) ⁶	233,458	89,980	45.31	143,478	50.53	66
Child's (DI)	61,464	18,264	27.28	43,200	30.62	782
Mother's	91,255	35,303	57.82	55,952	65.24	16
Lump-sum death payments ⁷	757,018	(⁸)	(⁸)	(⁸)	(⁸)	242
						1,145

¹ Distribution by type of monthly benefit estimated.

² Benefits under the old-age and survivors insurance (OASI) parts of the old-age, survivors, and disability insurance program are payable from the OASI trust fund to old-age (retired worker) beneficiaries and their dependents and to survivors of deceased workers. Benefits under the disability insurance (DI) part of the program are payable from the DI trust fund to disability insurance (disabled worker) beneficiaries and their dependents. Monthly benefits were first payable to dependents of disability insurance (disabled worker) beneficiaries for the month of September 1958, and were first represented in October 1958 awards.

³ Payable to disabled workers aged 50-64. Effective for months beginning August 1958, disability insurance benefits are not offset by other benefits payable because of disability.

⁴ Includes, as a small proportion, wife beneficiaries under age 65 with child beneficiaries in their care. At the end of June 1959 there were an estimated 122,000 such benefits in current-payment status.

⁵ Includes benefits payable to disabled persons aged 18 or over—dependent children of disabled, deceased, or retired workers—whose disability began before age 18. At the end of June 1959 there were an estimated 64,000 such benefits in current-payment status.

⁶ Distribution by type of claim for OASI child's benefits partly estimated.

⁷ There were 728,658 deceased workers represented in the fiscal year 1959 lump-sum awards.

⁸ Data not now available.

TABLE AF.—Comparative data

Item	Fiscal year		
	1959	1958	1957
Number of benefits in current-payment status, end of period:			
Total, OASI and DI.....	13, 181, 380	11, 905, 288	10, 342, 119
Total, OASI.....	12, 820, 164	11, 704, 913	10, 342, 119
Total, DI.....	361, 216	200, 375	-----
Amount of benefits paid (in millions):			
Total, OASI and DI.....	\$9, 388. 4	\$8, 043. 4	\$6, 514. 6
Total, OASI.....	9, 049. 1	7, 874. 9	6, 514. 6
Total, DI.....	339. 2	168. 4	-----
Number of persons aged 65 and over receiving monthly benefits, end of period ¹	9, 791, 000	8, 903, 000	7, 867, 000
Number of old-age (retired worker) benefits:			
Awarded.....	1, 047, 105	1, 172, 355	1, 412, 185
In current-payment status, end of period.....	7, 295, 640	6, 638, 500	5, 832, 253
Average old-age (retired worker) benefit:			
Awarded.....	² \$81. 16	\$71. 89	\$66. 10
In current-payment status, end of period.....	\$72. 19	\$65. 71	\$63. 99
Number of disability insurance (disabled worker) benefits:			
Awarded.....	128, 918	262, 090	-----
In current-payment status, end of period.....	275, 164	200, 375	-----
Average disability insurance (disabled worker) benefit:			
Awarded.....	³ \$91. 67	\$82. 13	-----
In current-payment status, end of period.....	\$88. 40	\$74. 42	-----

¹ Numbers estimated and shown to the nearest thousand. Excludes women aged 62-64 entitled to old-age, aged wife's (wives with no entitled children), widow's or parent's benefits; at the end of June 1959 there were an estimated 845,000 such benefits in current-payment status.

² Based on awards at the 1958 amendment benefit rates; the average old-age benefit awarded in fiscal year 1959 at the old benefit rates was \$75.20.

³ Based on awards at the 1958 amendment benefit rates; the average disability insurance benefit awarded in fiscal year 1959 at the old benefit rates was \$85.94.

CHARACTERISTICS OF OASI DISABILITY APPLICANTS

TABLE AG.—*Worker disability allowances: Number and percentage distribution of workers for whom a period of disability was allowed in 1957, by age and sex*

Age ¹	Total		Male		Female	
	Number	Percent	Number	Percent	Number	Percent
Total.....	165, 003	100. 0	134, 621	100. 0	30, 382	100. 0
Under 35.....	3, 665	2. 2	3, 056	2. 3	609	2. 0
35 to 39.....	3, 236	2. 0	2, 645	2. 0	591	1. 9
40 to 44.....	4, 171	2. 5	3, 361	2. 5	810	2. 7
45 to 49.....	7, 169	4. 3	5, 626	4. 2	1, 543	5. 1
50 to 54.....	28, 437	17. 2	21, 240	15. 8	7, 197	23. 7
55 to 59.....	44, 099	26. 7	34, 090	25. 3	10, 009	32. 9
60 to 64.....	63, 399	38. 4	55, 011	40. 9	8, 388	27. 6
65 and over.....	10, 827	6. 6	9, 592	7. 1	1, 235	4. 1

¹ Age on birthday in year application was filed.

TABLE AH.—*Worker disability allowances: Number and percentage distribution of workers for whom a period of disability was allowed in 1957, by age and sex, and by year of onset of disability*

Year of onset of disability	Age 1									
	Total		Under 35		35-49		50-64		65 and over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total-----	165, 003	100. 0	3, 665	100. 0	14, 576	100. 0	135, 935	100. 0	10, 827	100. 0
1957-----	6, 007	3. 6	39	1. 1	127	. 9	5, 715	4. 2	126	1. 2
1956-----	51, 716	31. 3	693	18. 9	2, 966	20. 3	46, 558	34. 3	1, 499	13. 8
1955-----	32, 629	19. 8	1, 016	27. 7	3, 254	22. 3	27, 526	20. 2	833	7. 7
1954-----	18, 200	11. 0	653	17. 8	1, 891	13. 0	15, 010	11. 0	646	6. 0
1953-----	12, 747	7. 7	381	10. 4	1, 350	9. 3	10, 287	7. 6	729	6. 7
1951-52-----	15, 665	9. 5	432	11. 8	1, 586	10. 9	12, 019	8. 8	1, 628	15. 0
1948-50-----	15, 705	9. 5	360	9. 8	1, 699	11. 7	11, 122	8. 2	2, 524	23. 3
1947 and earlier-----	12, 334	7. 5	91	2. 5	1, 703	11. 7	7, 698	5. 7	2, 842	26. 2
Male-----	134, 621	100. 0	3, 056	100. 0	11, 632	100. 0	110, 341	100. 0	9, 592	100. 0
1957-----	5, 117	3. 8	34	1. 1	98	. 8	4, 860	4. 4	125	1. 3
1956-----	44, 147	32. 8	579	18. 9	2, 463	21. 2	39, 636	35. 9	1, 469	15. 3
1955-----	27, 097	20. 1	860	28. 1	2, 628	22. 6	22, 837	20. 7	772	8. 0
1954-----	14, 783	11. 0	559	18. 3	1, 473	12. 7	12, 175	11. 0	576	6. 0
1953-----	10, 160	7. 5	318	10. 4	1, 045	9. 0	8, 162	7. 4	635	6. 6
1951-52-----	11, 886	8. 8	352	11. 5	1, 213	10. 4	8, 952	8. 1	1, 369	14. 3
1948-50-----	11, 946	8. 9	274	9. 0	1, 330	11. 4	8, 183	7. 4	2, 159	22. 5
1947 and earlier-----	9, 485	7. 0	80	2. 6	1, 382	11. 9	5, 536	5. 0	2, 487	25. 9
Female-----	30, 382	100. 0	609	100. 0	2, 944	100. 0	25, 594	100. 0	1, 235	100. 0
1957-----	890	2. 9	5	. 8	29	1. 0	855	3. 3	1	. 1

1956-----	7,569	24.9	114	18.7	503	17.1	6,922	27.0	30	2.4
1955-----	5,532	18.2	156	25.6	626	21.3	4,689	18.3	61	4.9
1954-----	3,417	11.2	94	15.4	418	14.2	2,835	11.1	70	5.7
1953-----	2,587	8.5	63	10.3	305	10.4	2,125	8.3	94	7.6
1951-52-----	3,779	12.4	80	13.1	373	12.7	3,067	12.0	259	21.0
1948-50-----	3,759	12.4	86	14.1	369	12.5	2,939	11.5	365	29.6
1947 and earlier-----	2,849	9.4	11	1.8	321	10.9	2,162	8.4	355	28.7

¹ Age on birthday in year application was filed.

TABLE A1.—*Worker disability allowances: Number and percentage distribution of workers for whom a period of disability was allowed in 1957 by age and mobility status*

[Based partly on 50-percent sample]

Mobility status when application was filed	Age ¹									
	Total		Under 35		35-49		50-64		65 and over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total-----	165,003	100.0	3,665	100.0	14,576	100.0	135,935	100.0	10,827	100.0
Institutionalized ² -----	20,112	12.2	2,267	61.9	5,416	37.2	11,488	8.5	941	8.7
Hospitalized ³ -----	3,970	2.4	169	4.6	472	3.2	3,155	2.3	174	1.6
Housebound-----	25,862	15.7	452	12.3	2,436	16.7	21,351	15.7	1,623	15.0
Ambulatory outside the home:										
With help-----	26,518	16.1	270	7.4	1,872	12.8	22,537	16.6	1,839	17.0
By self-----	88,541	53.7	507	13.8	4,380	30.0	77,404	56.9	6,250	57.7

¹ Age on birthday in year application was filed.

² Disabled person was confined to an institution (mental, tuberculosis, or chronic disease hospital, soldier's home, etc.).

³ Disabled person was a patient in a general hospital.

TABLE AJ.—*Worker disability allowances: Number of workers for whom a period of disability was allowed in 1957, by sex, and percentage distribution by diagnostic group and primary diagnosis*

Diagnostic group and primary diagnosis	International code	Total	Male	Female
Total number		165, 003	134, 621	30, 382
Total percent		100. 0	100. 0	100. 0
Infective and parasitic diseases	001-138	8. 4	9. 5	3. 7
Pulmonary tuberculosis	002	5. 2	6. 0	2. 0
Syphilis of central nervous system ¹	026	. 6	. 7	. 2
General paralysis of insane	025	. 6	. 6	. 2
Respiratory tuberculosis with mention of occupational disease of lung	001	. 4	. 5	(²)
Other		1. 6	1. 7	1. 3
Neoplasms	140-239	6. 4	6. 1	8. 1
Malignant neoplasm of trachea, and of bronchus and lung, specified as primary	162	. 6	. 7	. 1
Malignant neoplasm of rectum	154	. 5	. 5	. 6
Malignant neoplasm of lung and bronchus, unspecified as to whether primary or secondary	163	. 4	. 5	. 1
Malignant neoplasm of prostate	177	. 4	. 5	
Other		4. 5	3. 8	7. 3

Allergic, endocrine system, metabolic, and nutritional diseases-----	240-289	2.9	2.5	4.6
Diabetes mellitus-----	260	2.5	2.2	4.0
Thyroidosis with or without goiter-----	252	.1	(2)	.2
Gout-----	288	.1	.1	(2)
Other-----		.2	.2	.4
Diseases of the blood and blood-forming organs-----	290-299	.3	.2	.4
Pernicious and other hyperchronic anemias-----	290	.1	.1	.2
Other-----		.1	.1	.2
Mental, psychoneurotic, and personality disorders-----	300-328	7.9	7.5	9.8
Schizophrenic disorders (dementia praecox)-----	300	3.9	3.7	4.9
Involuntary melancholia-----	302	.5	.4	1.1
Manic-depressive reaction-----	301	.5	.4	.8
Other-----		3.0	3.0	3.0
Diseases of the nervous system and sense organs-----	330-398	21.9	22.2	20.9
Cerebral hemorrhage-----	331	5.0	5.0	5.0
Cerebral embolism and thrombosis-----	332	3.8	4.0	2.9
Paralysis agitans-----	350	1.7	1.7	1.7
Other-----		11.4	11.4	11.3

See footnotes at end of table, p. 165.

TABLE A.J.—*Worker disability allowances: Number of workers for whom a period of disability was allowed in 1957, by sex, and percentage distribution by diagnostic group and primary diagnosis—Continued*

Diagnostic group and primary diagnosis	International code	Total	Male	Female
Diseases of the circulatory system	400-468	32.4	32.1	33.8
Arteriosclerotic heart disease, including coronary disease	420	18.1	19.1	14.0
Hypertensive heart disease, with clinical type unspecified	443	6.2	5.5	9.1
Rheumatic heart disease of mitral valve	410	1.8	1.4	3.8
Certain types of myocardial degeneration	422	1.1	1.1	1.2
General arteriosclerosis	450	.8	1.0	.2
Other	-----	4.4	4.1	5.6
Diseases of the respiratory system	470-528	7.9	9.1	2.5
Emphysema	528	5.4	6.2	1.8
Pneumoconiosis due to silica and silicates (occupational)	523	1.8	2.2	(2)
Chronic bronchitis	502	.4	.4	.4
Other	-----	.3	.3	.3
Diseases of the digestive system	530-587	1.5	1.5	1.5
Cirrhosis of liver	581	.6	.7	.5
Ulcer of duodenum	541	.2	.2	.1
Ulcer of stomach	540	.1	.1	.1
Chronic enteritis and ulcerative colitis	572	.1	.1	.2
Other	-----	.4	.4	.6

Diseases of the genitourinary system.....	590-637	.6	.5	.8
Chronic nephritis.....	592	.2	.2	.3
Infections of kidney.....	600	.1	.1	.1
Calculi of kidney and ureter.....	602	.1	.1	.1
Other.....		.2	.2	.2
Diseases of the skin and cellular tissue.....	690-716	.2	.2	.3
Diseases of the bones and organs of movement.....	720-749	9.1	8.2	13.1
Rheumatoid arthritis and allied conditions.....	722	3.3	2.6	6.6
Osteoarthritis and allied conditions.....	723	2.8	2.7	3.5
Arthritis, with clinical type unspecified.....	725	.6	.5	.9
Residual deformities of the bones and joints ⁴	749	.5	.6	.3
Other.....		1.8	1.8	1.8
Congenital malformations.....	750-759	.4	.4	.5
Other ⁵		(²)	.1	(²)

¹ Other than tabes dorsalis and general paralysis of insane.

² Less than 0.05 percent.

³ Special modification of the International Code.

⁴ Deformities, such as malunion or nonunion of a fracture,

amputation, or shortened extremity, resulting from traumatic conditions.

⁵ Diagnoses not included in diagnostic group shown above, such as Jacksonian epilepsy, senility, chronic lead poisoning, etc.

TABLE AK.—Worker disability allowances: 10 primary diagnoses occurring most often among workers for whom a period of disability was allowed in 1957, by sex, and percent of total

Primary diagnosis	International code	Number	Percent	Cumulative percent
	Total			
1. Arteriosclerotic heart disease, including coronary disease-----	420	29,920	18.1	18.1
2. Hypertensive heart disease, with clinical type unspecified-----	443	10,217	6.2	24.3
3. Emphysema-----	1528	8,835	5.4	29.7
4. Pulmonary tuberculosis-----	002	8,618	5.2	34.9
5. Cerebral hemorrhage-----	331	8,226	5.0	39.9
6. Schizophrenic disorders (dementia praecox)-----	300	6,439	3.9	43.8
7. Cerebral embolism and thrombosis-----	332	6,312	3.8	47.6
8. Rheumatoid arthritis and allied conditions-----	722	5,469	3.3	50.9
9. Osteoarthritis and allied conditions-----	723	4,654	2.8	53.7
10. Diabetes mellitus-----	260	4,185	2.5	56.2
	Male			
1. Arteriosclerotic heart disease, including coronary disease-----	420	25,666	19.1	19.1
2. Emphysema-----	1528	8,291	6.2	25.3
3. Pulmonary tuberculosis-----	002	8,011	6.0	31.3
4. Hypertensive heart disease, with clinical type unspecified-----	443	7,459	5.5	36.8
5. Cerebral hemorrhage-----	331	6,704	5.0	41.8
6. Cerebral embolism and thrombosis-----	332	5,424	4.0	45.8
7. Schizophrenic disorders (dementia praecox)-----	300	4,958	3.7	49.5
8. Osteoarthritis and allied conditions-----	723	3,605	2.7	52.2
9. Rheumatoid arthritis and allied conditions-----	722	3,466	2.6	54.8
10. Pneumoconiosis due to silica and silicates (occupational)-----	523	2,973	2.2	57.0

	Female			
1. Arteriosclerotic heart disease, including coronary disease.....	420	4, 254	14. 0	14. 0
2. Hypertensive heart disease, with clinical type unspecified.....	443	2, 758	9. 1	23. 1
3. Rheumatoid arthritis and allied conditions.....	722	2, 003	6. 6	29. 7
4. Cerebral hemorrhage.....	331	1, 522	5. 0	34. 7
5. Schizophrenic disorders (dementia praecox).....	300	1, 481	4. 9	39. 6
6. Diabetes mellitus.....	260	1, 213	4. 0	43. 6
7. Rheumatic heart disease of mitral valve.....	410	1, 148	3. 8	47. 4
8. Osteoarthritis and allied conditions.....	723	1, 049	3. 5	50. 9
9. Cerebral embolism and thrombosis.....	332	888	2. 9	53. 8
10. Multiple sclerosis.....	345	753	2. 5	56. 3

¹ Special modification of the International Code.

TABLE AL.—*Worker disability allowances: 10 primary diagnoses occurring most often among workers for whom a period of disability was allowed in 1957, by age,¹ and percent of total*

Primary diagnosis	International code	Number	Percent	Cumulative percent
	Under age 50			
1. Schizophrenic disorders (dementia praecox)-----	300	4, 561	25. 0	25. 0
2. Pulmonary tuberculosis-----	002	2, 250	12. 3	37. 3
3. Multiple sclerosis-----	345	959	5. 3	42. 6
4. Arteriosclerotic heart disease, including coronary disease-----	420	680	3. 7	46. 3
5. Certain diseases of the spinal cord, including paralysis resulting from spinal cord injuries-----	357	581	3. 2	49. 5
6. Rheumatoid arthritis and allied conditions-----	722	530	2. 9	52. 4
7. Cerebral hemorrhage-----	331	387	2. 1	54. 5
8. Rheumatic heart disease of mitral valve-----	410	382	2. 1	56. 6
9. Encephalopathy (chronic brain syndrome)-----	2 358	365	2. 0	58. 6
10. Cerebral embolism and thrombosis-----	332	331	1. 8	60. 4

Aged 50-64

1. Arteriosclerotic heart disease, including coronary disease.....	420	27, 012	19. 9	19. 9
2. Hypertensive heart disease, with clinical type unspecified.....	443	9, 019	6. 6	26. 5
3. Emphysema.....	² 528	8, 020	5. 9	32. 4
4. Cerebral hemorrhage.....	331	7, 253	5. 3	37. 7
5. Pulmonary tuberculosis.....	002	6, 074	4. 5	42. 2
6. Cerebral embolism and thrombosis.....	332	5, 646	4. 2	46. 4
7. Rheumatoid arthritis and allied conditions.....	722	4, 658	3. 4	49. 8
8. Osteoarthritis and allied conditions.....	723	4, 025	3. 0	52. 8
9. Diabetes mellitus.....	260	3, 633	2. 7	55. 5
10. Pneumoconiosis due to silica and silicates (occupational).....	523	2, 622	1. 9	57. 4

Aged 65 and over

1. Arteriosclerotic heart disease, including coronary disease.....	420	2, 228	20. 6	20. 6
2. Hypertensive heart disease, with clinical type unspecified.....	443	939	8. 7	29. 3
3. Cerebral hemorrhage.....	331	586	5. 4	34. 7
4. Emphysema.....	² 528	556	5. 1	39. 8
5. Osteoarthritis and allied conditions.....	723	535	4. 9	44. 7
6. Cerebral embolism and thrombosis.....	332	335	3. 1	47. 8
7. Pulmonary tuberculosis.....	002	294	2. 7	50. 5
8. Rheumatoid arthritis and allied conditions.....	722	281	2. 6	53. 1
9. Vascular lesions affecting central nervous system ³	334	276	2. 5	55. 6
10. Diabetes mellitus.....	260	256	2. 4	58. 0

¹ Age on birthday in year application was filed.³ Other than subarachnoid, hemorrhage, cerebral hemorrhage, cerebral embolism and thrombosis, and spasm of cerebral arteries.² Special modification of the International Code.

TABLE AM.—Worker disability allowances: Number and percentage distribution of workers for whom a period of disability was allowed in 1957, by diagnostic group and by age and sex

Diagnostic group	Age 1							
	Total		Under 50		50 to 64		65 and over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	165, 003	100. 0	18, 241	100. 0	135, 935	100. 0	10, 827	100. 0
Infective and parasitic diseases	13, 882	8. 4	3, 110	17. 0	10, 211	7. 5	561	5. 2
Neoplasms	10, 642	6. 4	911	5. 0	9, 323	6. 9	408	3. 8
Allergic, endocrine system, metabolic, and nutritional diseases	4, 728	2. 9	351	1. 9	4, 095	3. 0	282	2. 6
Diseases of the blood and blood-forming organs	429	. 3	32	. 2	355	. 3	42	. 4
Mental, psychoneurotic, and personality disorders	13, 077	7. 9	5, 782	31. 7	6, 759	5. 0	536	5. 0
Diseases of the nervous system and sense organs	36, 213	21. 9	4, 154	22. 8	29, 656	21. 8	2, 403	22. 2
Diseases of the circulatory system	53, 527	32. 4	1, 810	9. 9	47, 552	35. 0	4, 165	38. 5
Diseases of the respiratory system	13, 005	7. 9	443	2. 4	11, 629	8. 6	933	8. 6
Diseases of the digestive system	2, 502	1. 5	163	. 9	2, 198	1. 6	141	1. 3
Diseases of the genitourinary system	914	. 6	94	. 5	772	. 6	48	. 4
Diseases of the skin and cellular tissue	339	. 2	54	. 3	263	. 2	22	. 2
Diseases of the bones and organs of movement	14, 974	9. 1	1, 175	6. 4	12, 545	9. 2	1, 254	11. 6
Congenital malformations	694	. 4	158	. 9	517	. 4	19	. 2
Other 2	77	(3)	4	(3)	60	(3)	13	. 1

Diagnostic group	Age 1							
	Total		Under 50		50 to 64		65 and over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
	Female							
Total	30,382	100.0	3,553	100.0	25,594	100.0	1,235	100.0
Infective and parasitic diseases	1,109	3.7	354	10.0	732	2.9	23	1.9
Neoplasms	2,461	8.1	214	6.0	2,207	8.6	40	3.2
Allergic, endocrine system, metabolic, and nutritional diseases	1,410	4.6	77	2.2	1,273	5.0	60	4.9
Diseases of the blood and blood-forming organs	118	.4	5	.1	108	.4	5	.4
Mental, psychoneurotic, and personality disorders	2,986	9.8	1,201	33.8	1,702	6.6	83	6.7
Diseases of the nervous system and sense organs	6,333	20.9	833	23.4	5,263	20.6	257	20.8
Diseases of the circulatory system	10,276	33.8	445	12.5	9,343	36.5	488	39.5
Diseases of the respiratory system	747	2.5	41	1.2	677	2.6	29	2.3
Diseases of the digestive system	456	1.5	23	.6	417	1.6	16	1.3
Diseases of the genitourinary system	228	.8	24	.7	200	.8	4	.3
Diseases of the skin and cellular tissue	81	.3	13	.4	67	.3	1	.1
Diseases of the bones and organs of movement	3,984	13.1	278	7.8	3,484	13.6	222	18.0
Congenital malformations	166	.5	45	1.3	116	.5	5	.4
Other 2	7	(3)	0	0	5	(3)	2	.2

¹ Age on birthday in year application was filed.

³ Less than 0.05 percent.

² Diagnoses not included in diagnostic groups shown above, such as Jacksonian epilepsy, senility, chronic lead poisoning, etc.

TABLE AN—Worker disability allowances: Number of workers for whom a period of disability was allowed in 1957, by diagnostic group and age, and percentage distribution by year of onset of disability

Diagnostic group and age ¹	Total		Percentage distribution by year of onset of disability							
	Number	Percent	1957	1956	1955	1954	1953	1951-52	1948-50	1947 and earlier
	165, 003	100. 0	3. 6	31. 3	19. 8	11. 0	7. 7	9. 5	9. 5	7. 5
Total	18, 241	100. 0	. 9	20. 1	23. 4	13. 9	9. 5	11. 1	11. 3	9. 8
Under 50	135, 935	100. 0	4. 2	34. 3	20. 2	11. 0	7. 6	8. 8	8. 2	5. 7
50-64	10, 827	100. 0	1. 2	13. 8	7. 7	6. 0	6. 7	15. 0	23. 3	26. 2
65 and over										
Infective and parasitic diseases	13, 882	100. 0	2. 8	28. 0	19. 2	9. 8	7. 2	10. 3	11. 8	11. 0
Under 50	3, 110	100. 0	1. 0	27. 2	28. 3	12. 3	6. 9	9. 2	8. 3	6. 8
50-64	10, 211	100. 0	3. 5	29. 2	17. 0	9. 2	7. 2	10. 5	12. 1	11. 2
65 and over	561	100. 0	. 7	9. 6	8. 4	5. 5	7. 1	14. 1	25. 1	29. 4
Neoplasms	10, 642	100. 0	7. 8	50. 2	21. 2	7. 6	4. 2	3. 9	3. 3	1. 8
Under 50	911	100. 0	2. 3	39. 5	32. 7	12. 8	4. 8	3. 6	2. 4	1. 8
50-64	9, 323	100. 0	8. 5	52. 0	20. 5	7. 2	4. 1	3. 4	3. 0	1. 3
65 and over	408	100. 0	2. 9	33. 3	11. 5	6. 1	6. 6	15. 0	12. 0	12. 5
Allergic, endocrine system, metabolic, and nutritional diseases	4, 728	100. 0	3. 4	29. 7	21. 0	12. 2	8. 4	10. 6	9. 4	5. 4
Under 50	351	100. 0	. 6	26. 5	27. 4	16. 0	12. 5	9. 4	6. 0	1. 7
50-64	4, 095	100. 0	3. 8	31. 3	21. 3	12. 2	8. 1	10. 0	8. 7	4. 7
65 and over	282	100. 0	. 7	11. 3	9. 2	7. 1	7. 4	19. 9	24. 1	20. 2
Mental, psychoneurotic, and personality disorders	13, 077	100. 0	1. 4	18. 1	19. 0	12. 7	9. 1	11. 7	14. 8	13. 2
Under 50	5, 782	100. 0	. 9	13. 1	20. 2	14. 0	10. 2	12. 6	14. 6	14. 4
50-64	6, 759	100. 0	1. 8	23. 2	18. 9	12. 4	8. 5	10. 5	13. 7	11. 1
65 and over	536	100. 0	. 4	7. 3	6. 7	3. 5	5. 6	16. 8	32. 1	27. 6

See footnotes at end of table, p. 174.

TABLE AN.—*Worker disability allowances: Number of workers for whom a period of disability was allowed in 1957, by diagnostic group and age, and percentage distribution by year of onset of disability—Continued*

Diagnostic group and age ¹	Total		Percentage distribution by year of onset of disability							
	Number	Percent	1957	1956	1955	1954	1953	1951-52	1948-50	1947 and earlier
Diseases of the nervous system and sense organs.....	36,213	100.0	3.2	29.8	19.4	10.8	7.7	10.1	10.5	8.5
Under 50.....	4,154	100.0	.7	19.1	22.2	13.4	10.0	11.4	12.4	10.8
50-64.....	29,656	100.0	3.7	32.8	20.0	10.9	7.5	9.5	9.1	6.6
65 and over.....	2,403	100.0	1.2	12.0	6.9	5.7	6.8	15.1	24.1	28.0
Diseases of the circulatory system.....	53,527	100.0	4.6	35.1	20.7	11.0	7.3	8.7	7.5	5.1
Under 50.....	1,810	100.0	1.2	26.0	27.0	16.1	10.4	10.3	5.4	3.7
50-64.....	47,552	100.0	5.0	37.2	21.6	11.2	7.2	8.1	6.4	3.5
65 and over.....	4,165	100.0	1.4	16.2	8.4	6.4	7.1	15.0	22.0	23.6
Diseases of the respiratory system.....	13,005	100.0	3.1	30.8	20.3	12.7	9.3	9.5	8.7	5.6
Under 50.....	443	100.0	.5	19.9	20.1	16.7	11.7	10.8	15.3	5.0
50-64.....	11,629	100.0	3.3	32.7	21.3	13.1	9.4	8.8	7.1	4.2
65 and over.....	933	100.0	.9	13.2	7.6	6.6	6.3	16.9	25.1	23.4
Diseases of the digestive system.....	2,502	100.0	3.2	30.9	21.1	12.7	9.9	9.1	8.3	4.9
Under 50.....	163	100.0	.6	22.7	28.2	14.7	12.3	10.4	6.7	4.3
50-64.....	2,198	100.0	3.5	32.5	21.4	13.1	9.6	8.8	7.3	3.7
65 and over.....	141	100.0	1.4	16.3	7.1	2.8	10.6	12.8	25.5	23.4
Diseases of the bones and organs of movement.....	14,974	100.0	2.0	23.9	16.8	11.8	9.1	11.8	12.8	11.8
Under 50.....	1,175	100.0	.3	12.9	16.5	15.6	11.3	14.0	15.8	13.5
50-64.....	12,545	100.0	2.2	26.5	17.9	12.0	9.3	11.5	11.4	9.0
65 and over.....	1,254	100.0	.6	8.7	5.5	5.9	5.3	12.6	24.0	37.4
Other ²	2,453	-----	-----	-----	-----	-----	-----	-----	-----	-----

¹ Age on birthday in year application was filed.² Too few cases in component diagnostic groups for a reliable distribution.

TABLE AO.—*Worker disability allowances: Number and percentage distribution of workers for whom a period of disability was allowed in 1957, by age, sex, marital status, and number of children under age 18*

[Based partly on 50-percent sample]

Sex, marital status, and number of children under age 18 of disabled worker	Number of disabled workers	Percentage distribution of disabled workers aged—1				
		Total	Under 35	35-49	50-64	65 and over
Total number.....	165, 003	165, 003	3, 665	14, 576	135, 935	10, 827
Male						
Total number.....	134, 621	134, 621	3, 056	11, 632	110, 341	9, 592
Total percent.....	---	100. 0	100. 0	100. 0	100. 0	100. 0
Married.....	98, 117	72. 9	39. 3	61. 8	75. 3	69. 2
No children.....	72, 507	53. 9	6. 9	19. 7	58. 0	62. 2
1 or more children.....	23, 929	17. 8	30. 9	40. 5	16. 1	5. 7
1 child.....	11, 702	8. 7	9. 3	12. 7	8. 7	3. 6
2 children.....	5, 919	4. 4	11. 0	11. 8	3. 7	1. 0
3 children.....	2, 875	2. 1	6. 5	7. 0	1. 7	. 4
4 children.....	1, 578	1. 2	2. 3	4. 1	. 9	. 3
5 or more children.....	1, 855	1. 4	1. 8	4. 7	1. 1	. 4
Number of children unknown.....	1, 681	1. 2	1. 4	1. 6	1. 2	1. 3

See footnotes at end table, p. 177.

TABLE AO.—*Worker disability allowances: Number and percentage distribution of workers for whom a period of disability was allowed in 1957, by age, sex, marital status, and number of children under age 18—Continued*

[Based partly on 50-percent sample]

Sex, marital status, and number of children under age 18 of disabled worker	Number of disabled workers	Percentage distribution of disabled workers aged—1				
		Total	Under 35	35-49	50-64	65 and over
	Male					
Nonmarried ²	30, 774	22. 9	42. 8	28. 1	21. 4	27. 1
No children	26, 479	19. 7	32. 6	20. 2	18. 8	24. 9
1 or more children	2, 222	1. 7	4. 5	4. 8	1. 3	. 6
1 child	1, 336	1. 0	2. 2	2. 4	. 9	. 4
2 children	572	. 4	1. 7	1. 5	. 3	. 2
3 or more children	314	. 2	. 6	1. 0	. 2	(³)
Number of children unknown	2, 073	1. 5	5. 7	3. 1	1. 3	1. 7
Marital status unknown	5, 730	4. 3	18. 0	10. 1	3. 3	3. 7
No children	389	. 3	. 1	. 3	. 3	. 4
1 or more children	90	. 1	. 3	. 1	. 1	. 1
Number of children unknown	5, 251	3. 9	17. 6	9. 7	3. 0	3. 2

Female

	30, 382	30, 382	609	2, 944	25, 594	1, 235
Total number-----	30, 382	100. 0	100. 0	100. 0	100. 0	100. 0
Total percent-----						
Married-----	14, 769	48. 6	26. 9	43. 9	50. 4	33. 0
No children-----	13, 412	44. 1	12. 8	32. 3	46. 8	31. 9
1 or more children-----	1, 083	3. 6	12. 0	10. 3	2. 7	. 6
1 child-----	769	2. 5	6. 9	6. 0	2. 1	. 5
2 children-----	224	. 7	4. 1	3. 0	. 4	. 2
3 or more children-----	90	. 3	1. 0	1. 4	. 2	0
Number of children unknown-----	274	. 9	2. 1	1. 4	. 8	. 5
Nonmarried ² -----	14, 127	46. 5	49. 9	44. 6	45. 9	61. 8
No children-----	12, 977	42. 7	36. 3	36. 5	42. 8	59. 0
1 or more children-----	405	1. 3	6. 7	4. 4	. 9	0
1 child-----	306	1. 0	4. 8	2. 9	. 8	0
2 children-----	85	. 3	1. 6	1. 3	. 1	0
3 or more children-----	14	(³)	. 3	. 3	(³)	0
Number of children unknown-----	745	2. 5	6. 9	3. 6	2. 2	2. 8
Marital status unknown-----	1, 486	4. 9	23. 2	11. 5	3. 7	5. 2
No children-----	113	. 4	. 7	. 5	. 3	. 8
1 or more children-----	4	(³)	0	. 1	(³)	0
Number of children unknown-----	1, 369	4. 5	22. 5	11. 0	3. 3	4. 4

¹ Age on birthday in year application was filed.² Single, widowed, and divorced.³ Less than 0.05 percent.

TABLE AP.—*Worker disability denials: Number and percentage distribution of workers for whom a period of disability was denied in 1957, by age and sex, and by reason for denial*

[Based on 20-percent sample]

Reason for denial	Age 1									
	Total		Under 35		35-49		50-64		65 and over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total.....	125, 720	100. 0	2, 985	100. 0	11, 105	100. 0	101, 735	100. 0	9, 895	100. 0
Failed to meet quarters-of-coverage requirements at any time.....	3, 450	2. 7	315	10. 6	560	5. 0	1, 355	1. 3	1, 220	12. 3
Was not disabled at latest time the quarters-of-coverage requirements were met.....	15, 250	12. 1	250	8. 4	970	8. 7	12, 255	12. 0	1, 775	17. 9
Failed to meet medical standards for disability.....	89, 400	71. 1	2, 080	69. 7	7, 835	70. 6	74, 800	73. 5	4, 685	47. 3
Met medical standards for disability but able to engage in substantial gainful activity.....	2, 280	1. 8	50	1. 7	230	2. 1	1, 850	1. 8	150	1. 5
Failed to furnish sufficient evidence.....	13, 440	10. 7	255	8. 5	1, 385	12. 5	10, 785	10. 6	1, 015	10. 3
Failed to meet the requirements of 6 months' continuous disability.....	950	. 8	5	. 2	5	(2)	85	. 1	855	8. 6
Other.....	950	. 8	30	1. 0	120	1. 1	605	. 6	195	2. 0

	Male									
Total	90,760	100.0	2,390	100.0	8,295	100.0	71,545	100.0	8,530	100.0
Failed to meet quarters-of-coverage requirements at any time	2,585	2.8	230	9.6	360	4.3	940	1.3	1,055	12.4
Was not disabled at latest time the quarters-of-coverage requirements were met	11,715	12.9	180	7.5	740	8.9	9,210	12.9	1,585	18.6
Failed to meet medical standards for disability	63,025	69.4	1,695	70.9	5,935	71.5	51,390	71.8	4,005	47.0
Met medical standards for disability but able to engage in substantial gainful activity	1,980	2.2	35	1.5	180	2.2	1,615	2.3	150	1.8
Failed to furnish sufficient evidence	9,870	10.9	220	9.2	975	11.8	7,860	11.0	815	9.6
Failed to meet the requirements of 6 months' continuous disability	835	.9	5	.2	0	0	75	.1	755	8.9
Other	750	.8	25	1.0	105	1.3	455	.6	165	1.9

See footnotes at end of table, p. 180.

[Based on 20-percent sample]

Reason for denial	Age 1									
	Total		Under 35		35-49		50-64		65 and over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Female										
Total-----	34,960	100.0	595	100.0	2,810	100.0	30,190	100.0	1,365	100.0
Failed to meet quarters-of-coverage requirements at any time-----	865	2.5	85	14.3	200	7.1	415	1.4	165	12.1
Was not disabled at latest time the quarters-of-coverage requirements were met-----	3,535	10.1	70	11.8	230	8.2	3,045	10.1	190	13.9
Failed to meet medical standards for disability-----	26,375	75.4	385	64.7	1,900	67.6	23,410	77.5	680	49.8
Met medical standards for disability but able to engage in substantial gainful activity-----	300	.9	15	2.5	50	1.8	235	.8	0	0
Failed to furnish sufficient evidence-----	3,570	10.2	35	5.9	410	14.6	2,925	9.7	200	14.7
Failed to meet the requirements of 6 months' continuous disability-----	115	.3	0	0	5	.2	10	(2)	100	7.3
Other-----	200	.6	5	.8	15	.5	150	.5	30	2.2

¹ Age on birthday in year application was filed.² Less than 0.05 percent.

TABLE AQ.—Worker disability denials: Number and percentage distribution of workers for whom a period of disability was denied in 1957, by diagnostic group and by age and sex
 [Based on 20-percent sample]

Diagnostic group	Age ¹					
	Total		Under 50		50-64	
	Number	Percent	Number	Percent	Number	Percent
	Total					
Total	125,720	100.0	14,090	100.0	101,735	100.0
Infective and parasitic diseases	7,615	6.1	2,265	16.1	5,035	4.9
Neoplasms	2,690	2.1	205	1.5	2,320	2.3
Allergic, endocrine system, metabolic, and nutritional diseases	4,065	3.2	225	1.6	3,580	3.5
Diseases of the blood and blood-forming organs	515	.4	35	.2	425	.4
Mental, psychoneurotic, and personality disorders	10,520	8.4	3,705	26.3	6,425	6.3
Diseases of the nervous system and sense organs	11,460	9.1	1,105	7.8	9,410	9.2
Diseases of the circulatory system	26,460	21.0	1,040	7.4	23,020	22.6
Diseases of the respiratory system	6,465	5.1	320	2.3	5,640	5.5
Diseases of the digestive system	7,435	5.9	440	3.1	6,395	6.3
Diseases of the genitourinary system	2,435	1.9	135	1.0	2,135	2.1
Diseases of the skin and cellular tissue	950	.8	85	.6	835	.8
Diseases of the bones and organs of movement	29,050	23.1	2,210	15.7	24,790	24.4
Congenital malformations	280	.2	55	.4	220	.2
Symptoms, senility, and ill-defined conditions	740	.6	75	.5	590	.6
Other ³	40	(²)	0	0	35	(²)
No medical evidence in file ⁴	15,000	11.9	2,190	15.5	10,880	10.7
					9,895	9.7
						100.0
						100.0
						3.2
						1.7
						2.6
						.6
						3.9
						9.6
						24.3
						5.1
						6.1
						1.7
						.3
						20.7
						.1
						.8
						.1
						19.5

See footnotes at end of table, p. 183.

[Based on 20-percent sample]

Diagnostic group	Age ¹							
	Total		Under 50		50-64		65 and over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Male								
Total	90,760	100.0	10,685	100.0	71,545	100.0	8,530	100.0
Infective and parasitic diseases	6,655	7.3	1,930	18.1	4,425	6.2	300	3.5
Neoplasms	1,530	1.7	115	1.1	1,270	1.8	145	1.7
Allergic, endocrine system, metabolic, and nutritional diseases	2,275	2.5	140	1.3	1,940	2.7	195	2.3
Diseases of the blood and blood-forming organs	260	.3	5	(²)	210	.3	45	.5
Mental, psychoneurotic, and personality disorders	7,395	8.1	2,870	26.9	4,195	5.9	330	3.9
Diseases of the nervous system and sense organs	8,830	9.7	885	8.3	7,100	9.9	845	9.9
Diseases of the circulatory system	18,465	20.3	760	7.1	15,645	21.9	2,060	24.2
Diseases of the respiratory system	5,685	6.3	265	2.5	4,940	6.9	480	5.6
Diseases of the digestive system	5,420	6.0	325	3.0	4,605	6.4	490	5.7
Diseases of the genitourinary system	1,125	1.2	50	.5	945	1.3	130	1.5
Diseases of the skin and cellular tissue	680	.7	55	.5	595	.8	30	.4
Diseases of the bones and organs of movement	20,650	22.8	1,735	16.2	17,165	24.0	1,750	20.5
Congenital malformations	195	.2	20	.2	170	.2	5	.1
Symptoms, senility, and ill-defined conditions	485	.5	50	.5	365	.5	70	.8
Other ³	40	(²)	0	0	35	(²)	5	.1
No medical evidence in file ⁴	11,070	12.2	1,480	13.9	7,940	11.1	1,650	19.3

TABLE AR.—*Childhood, disability allowances: Number of children found disabled in 1957, by sex, and percentage distribution by diagnostic group and primary diagnosis*

Diagnostic group and primary diagnosis	International Code	Total	Male	Female
Total number.....		36,267	16,938	19,329
Total percent.....		100.0	100.0	100.0
Infective and parasitic diseases.....	001-138	4.3	3.8	4.6
Late effects of acute poliomyelitis.....	081	2.5	2.0	2.9
Late effects of acute infectious encephalitis.....	083	1.0	1.2	.9
Congenital syphilis.....	020	.3	.4	.3
Other.....		.4	.3	.5
Neoplasms.....	140-239	.2	.2	.3
Allergic, endocrine system, metabolic, and nutritional diseases.....	240-289	2.7	1.8	3.4
Myxoedema and cretinism.....	253	2.1	1.3	2.7
Diseases of pituitary gland.....	272	.2	.2	.3
Polyglandular dysfunction and other diseases of endocrine glands.....	277	.2	.2	.2
Other.....		.2	.1	.2
Diseases of the blood and blood-forming organs.....	290-299	.1	.1	(1)
Mental, psychoneurotic, and personality disorders.....	300-328	47.4	47.5	47.2
Mental deficiency.....	325	45.0	45.0	45.1
Schizophrenic disorders (dementia praecox).....	300	1.5	1.7	1.4
Other.....		.8	.8	.7
Diseases of the nervous system and sense organs.....	330-398	38.8	40.1	37.6
Cerebral spastic infantile paralysis with mental deficiency 2.....	349	14.7	16.0	13.6
Cerebral spastic infantile paralysis.....	351	8.4	9.0	7.9
Epilepsy with mental deficiency.....	359	6.6	6.5	6.7
Late effects of intracranial abscess or pyogenic infection.....	344	3.0	2.9	3.1
Other.....		6.1	5.8	6.3

Diseases of the circulatory system-----	400-468	.4			.5
Diseases of mitral valve-----	410	.2		.2	.3
Other-----		.1		.1	.2
Diseases of the respiratory system-----	470-528	.1		.1	.1
Diseases of the digestive system-----	530-587	(1)		(1)	(1)
Diseases of the genitourinary system-----	590-637	(1)		(1)	.1
Diseases of the skin and cellular tissue-----	690-716	(1)		(1)	(1)
Diseases of the bones and organs of movement-----	720-749	2.5		2.5	2.4
Muscular dystrophy and other diseases of muscle, tendon, and fascia-----	744	1.0		1.4	.6
Rheumatoid arthritis and allied conditions-----	722	.9		.6	1.1
Other-----		.6		.6	.7
Congenital malformations-----	750-759	3.6		3.5	3.6
Congenital hydrocephalus-----	752	1.1		1.3	.9
Congenital cataract and other congenital malformations of nervous system and sense organs-----	753	.9		.8	.9
Congenital malformations of bone and joint-----	758	.6		.5	.7
Spina bifida and meningocele-----	751	.5		.4	.6
Other-----		.6		.5	.6
Other ³ -----		(1)		(1)	0

¹ Less than 0.05 percent.³ Diagnoses not included in diagnostic groups shown above.² Special modification of the International Code.

TABLE AS.—*Childhood disability allowances: 10 primary diagnoses occurring most often among children who were found disabled in 1957, by sex, and percent of total*

Primary diagnosis	International Code	Number	Percent	Cumulative percent
Total				
1. Mental deficiency-----	325	16,332	45.0	45.0
2. Cerebral spastic infantile paralysis with mental deficiency-----	1 349	5,338	14.7	59.7
3. Cerebral spastic infantile paralysis-----	351	3,041	8.4	68.1
4. Epilepsy with mental deficiency-----	1 359	2,394	6.6	74.7
5. Late effects of intracranial abscess or pyogenic infection-----	344	1,087	3.0	77.7
6. Late effects of acute poliomyelitis-----	081	906	2.5	80.2
7. Epilepsy-----	353	881	2.4	82.6
8. Myxoedema and cretinism-----	253	748	2.1	84.7
9. Schizophrenic disorders (dementia praecox)-----	300	562	1.5	86.2
10. Congenital hydrocephalus-----	752	384	1.1	87.3
Male				
1. Mental deficiency-----	325	7,619	45.0	45.0
2. Cerebral spastic infantile paralysis with mental deficiency-----	1 349	2,706	16.0	61.0
3. Cerebral spastic infantile paralysis-----	351	1,520	9.0	70.0
4. Epilepsy with mental deficiency-----	1 359	1,095	6.5	76.5
5. Late effects of intracranial abscess or pyogenic infection-----	344	488	2.9	79.4
6. Epilepsy-----	353	365	2.2	81.6
7. Late effects of acute poliomyelitis-----	081	344	2.0	83.6
8. Schizophrenic disorders (dementia praecox)-----	300	283	1.7	85.3
9. Muscular dystrophy and other diseases of muscle, tendon, and fascia-----	744	230	1.4	86.7
10. Myxoedema and cretinism-----	253	220	1.3	88.0

	Female			
1. Mental deficiency-----	325	8,713	45.1	45.1
2. Cerebral spastic infantile paralysis with mental deficiency-----	1 349	2,632	13.6	58.7
3. Cerebral spastic infantile paralysis-----	351	1,521	7.9	66.6
4. Epilepsy with mental deficiency-----	1 359	1,299	6.7	73.3
5. Late effects of intracranial abscess or pyogenic infection-----	344	599	3.1	76.4
6. Late effects of acute poliomyelitis-----	081	562	2.9	79.3
7. Myxoedema and cretinism-----	253	528	2.7	82.0
8. Epilepsy-----	353	516	2.7	84.7
9. Schizophrenic disorders (dementia praecox)-----	300	279	1.4	86.1
10. Rheumatoid arthritis and allied conditions-----	722	207	1.1	87.2

¹ Special modification of the International Code.

	Female									
	299	13.2	108	13.8	60	10.9	88	13.5	43	15.4
Failed to furnish sufficient evidence-----	384	17.0	40	5.1	99	18.1	152	23.3	93	33.3
Was not disabled before age 18-----	37	1.6	9	1.1	10	1.8	11	1.7	7	2.5
Other-----										
Total-----	2,609	100.0	613	100.0	600	100.0	885	100.0	511	100.0
Failed to meet medical standards for disability-----	1,770	67.8	487	79.4	409	68.2	572	64.6	302	59.1
Met medical standards for disability but able to engage in substantial gainful activity-----	17	.7	1	.2	3	.5	12	1.4	1	.2
Failed to furnish sufficient evidence-----	347	13.3	101	16.5	73	12.2	109	12.3	64	12.5
Was not disabled before age 18-----	444	17.0	22	3.6	107	17.8	180	20.3	135	26.4
Other-----	31	1.2	2	.3	8	1.3	12	1.4	9	1.8

¹ Age on birthday in year application was filed.

CONTINUING DISABILITY EXPERIENCE: CESSATIONS OF PERIODS OF DISABILITY, 1958

I. GENERAL

The procedures followed in determining continuance or cessation of disability once a period of disability has been established are outlined in Part V of the fact book.

The following tables contain selected data on the Bureau's continuing disability experience during 1958, especially terminations of periods of disability. The data relate to disability freeze and benefit cases only. A small number of childhood disability cases are excluded because, though small in number, they would distort the data on disabled workers. The tables also exclude about 71,000 cases in which, on the basis of the evidence already in the file, it was determined that no issue of continuing disability existed and the disability continued. They are based, therefore, only on those cases in which a formal determination of continuance or cessation of disability was made after a field investigation. Routine statistics are collected only on termination cases and those continuances disposed of after a field investigation. The tables show the characteristics of about 35,400 formal determinations of the latter sort. In evaluating these data, it should be borne in mind that the question of continuing disability arises in only a small percentage of cases in which a period of disability has been established.

II. CASE CHARACTERISTICS: SOME HIGHLIGHTS

A. Age and sex (table AU)

1. Of the total number of cases investigated, close to one out of five resulted in cessation of the period of disability. The proportion of males terminated was higher than that for females—19.3 percent compared with 14.4 percent.

2. The likelihood of cessation varied with age. For those under age 35, 30 percent of the continuing disability investigations resulted in a finding of cessation. The cessation rate fell to a low of about 13.5 percent for those aged 55-64, inclusive.

B. Reason for continuance or cessation (table AV)

1. About 8 out of 10 of the findings of cessation were made on the basis of evidence of the individual's return to work, which demonstrated ability to engage in substantial gainful activity. In most of these cases, it was not necessary to evaluate the extent, if any, to which there was improvement in the worker's medical condition. Almost all of the remaining cessations were based solely on evidence of improvement in the disabled worker's medical condition.

2. In about 8 out of 10 of the continuances, the disabled worker had not engaged in any work activity. Of this group 4 out of 10 were institutionalized.

Types of disease (tables AW and AX)

1. Four types of disease accounted for close to 9 out of 10 of the total number of cases in which findings of cessation were made:

	<i>Percent</i>
(a) Infective and parasitic diseases (primarily TB)	39
(b) Mental, psychoneurotic and personality disorders	25
(c) Diseases of the circulatory system (primarily heart disease)	15
(d) Diseases of the nervous system and sense organs	8

2. The relative order of importance of the disease types listed above is heavily influenced by the fact that applicants with these diseases were the largest groups by number among the total number of investigated cases. It may be instructive, therefore, to look also at comparative "cessation rates"—rates derived by dividing the number of cessations in a particular disease group by the total number of cases with the same type of disease that were investigated. The types of disease showing the highest rates of cessation among those investigated were:

	<i>Percent</i>
(a) Infective and parasitic diseases (especially TB)	35
(b) Genitourinary diseases	25
(c) Diseases of the skin and cellular tissue	23
(d) Diseases of the digestive system	22

3. Diseases of the circulatory system and mental, psychoneurotic and personality disorders had relatively low cessation rates. Yet, these diseases are of the types accounting for the largest numbers of people allowed a disability under the Social Security Act.

D. Recency of onset of disability (table AY)

1. Close to three out of four of the workers whose periods of disability were terminated in 1958 after investigation were disabled for 5 years or less. By contrast, only a little over half of the workers whose periods of disability were continued had been disabled for so long a period of time. The difference in length of disability is most marked among the younger workers. Almost 8 out of 10 of the workers under 35 whose periods of disability were terminated were disabled for 5 years or less. Less than half of the comparable age group among the continuances were disabled for so long a period of time.

E. Employment and earnings (tables AZ, BA, and BB)

1. Of the persons found no longer disabled (cessations), two out of three had weekly or monthly earnings during the period covered by the investigation that were equivalent to an annual rate of \$2,400 or more. About 8 out of 10 had earnings equivalent to an annual rate of \$1,200 or more. The information collected by the Bureau on earnings relates of course only to the period covered by the continuing disability investigation and is in terms of average weekly earnings for wage earners or net monthly income for self-employed persons. To convert these to annual earnings it has been assumed that these individuals worked continuously through the year.

2. Of the persons determined to be still disabled (continuances) only about one out of eight had postallowance earnings. While 1 out of 10 of the continuances had earnings equivalent to an annual rate of \$2,400 or more, in a majority of these cases the earnings were associated with an unsuccessful work attempt.

3. It is significant to note that the earnings that led to investigation of 6 out of 10 of the continuances were the result of an unsuccessful work attempt. In other words, the individual began to work but was unable to continue after a short time. In most of the remaining continuances with earnings during the period of the continuing disability investigation the work involved did not represent substantial gainful activity because the earnings were from work pursuant to a vocational rehabilitation program, or from made work, or represented termination pay or sick pay.

4. The likelihood of cessation increased with increasing earnings.

5. About 7 out of 10 of the workers found no longer disabled (cessations) were employed in the following four types of occupations:

	<i>Percent</i>
(a) Clerical, sales, and related occupations.....	20
(b) Service occupation.....	20
(c) Skilled manual occupations.....	16
(d) Semiskilled manual occupations.....	15

6. It is significant to note that less than 1 out of 10 of the cessations was engaged in unskilled manual occupations.

7. The overwhelming proportion of formerly disabled workers was engaged in private competitive wage employment—about 8 out of 10. Less than 1 out of 10 was self-employed.

8. Of the more than 9,300 disabled workers with postallowance employment only 226 were working in sheltered workshops during the period covered by the continuing disability investigation. Of these 226 persons, 77 or about 1 out of 3 were found no longer disabled.

TABLE AU.—Continuing disability determinations: Number of determinations made after field investigation, and number and percent of disability cessations by age and sex, 1958
[Disability freeze and benefit cases only ¹]

Age ²	All cases			Male		Female		
	Total number	Cessation cases		Total number	Cessation cases	Total number	Cessation cases	
		Number	Percent of total		Number	Percent of total	Number	Percent of total
All ages-----	35, 378	6, 543	18. 5	29, 421	5, 687	19. 3	856	14. 4
Under 35-----	2, 077	623	30. 0	1, 709	513	30. 0	110	29. 9
35 to 49-----	8, 209	2, 084	25. 4	6, 704	1, 757	26. 2	327	21. 7
50 to 54-----	6, 941	1, 257	18. 1	5, 590	1, 092	19. 5	165	12. 2
55 to 59-----	8, 171	1, 098	13. 4	6, 552	961	14. 7	137	8. 5
60 to 64-----	8, 704	1, 180	13. 6	7, 655	1, 089	14. 2	91	8. 7
65 and over ³ -----	1, 276	301	23. 6	1, 211	275	22. 7	26	40. 0

¹ Excludes 481 childhood disability cases of which 80 were terminated and 401 continued.

² Age attained in 1958.

³ Investigation of continuing disability based on events occurring before attainment of age 65.

TABLE AV.—Continuing disability determinations: Number of determinations made after field investigation by cessation or continuance and age, and percentage distribution by reason for continuance or cessation, 1958

[Disability freeze and benefit cases only ¹]

Type of final action and reason for action	All cases	Under 35	35 to 49	50 to 54	55 to 59	60 to 64	65 and over ²
CESSATIONS							
Total number.....	6,543	623	2,084	1,257	1,098	1,180	301
Total percent.....	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Engaging in work activity—severity of condition not improved.....	2.1	2.1	1.8	2.0	1.3	3.0	3.7
Engaging in work activity—severity of condition not determined.....	71.6	80.1	79.9	61.3	61.5	70.0	82.3
Engaging in work activity—severity of condition improved.....	5.7	6.6	5.5	6.4	5.9	5.4	3.3
Medical condition improved—no work activity.....	17.3	8.6	10.0	26.5	27.0	18.6	6.0
Other.....	3.3	2.6	2.8	3.8	4.3	3.0	4.7
CONTINUANCES							
Total number.....	28,835	1,454	6,125	5,681	7,079	7,535	961
Total percent.....	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No work activity—impairment still disabling.....	47.3	14.2	21.2	56.0	61.6	56.0	39.3
Disabled person institutionalized—no work activity.....	33.1	71.3	67.7	28.6	21.1	15.6	7.1
Earnings not from work activity ³	6.9	1.1	1.2	4.0	6.8	12.6	24.9
Unsuccessful work attempt.....	7.5	9.9	6.4	6.9	6.2	8.8	15.2
Work detrimental to health.....	.2	.2	.1	.1	.2	.3	.5

	4. 4	2. 7	2. 7	3. 6	3. 6	6. 4	12. 3
Other work activity—not substantial gainful-----							
Work pursuant to vocational rehabilitation pro- gram-----	. 3	. 3	. 2	. 3	. 3	. 2	. 3
Statutorily blind-----	. 3	. 3	. 5	. 5	. 2	. 1	. 4

³ Termination pay, sick pay, etc.

¹ Excludes 481 childhood disability cases.

² Continuing disability investigation based on events occurring prior to age 65.

TABLE AW.—Continuing disability determinations: Number and percent of determinations made after field investigation by continuance and cessation and by diagnostic group and selected primary diagnoses, 1958

[Disability freeze and benefit cases only ¹]								
Diagnostic group and selected primary diagnosis ²	International code ³	Total cases		Continuances		Cessations		Cessation as percent of total
		Number	Percent	Number	Percent	Number	Percent	
All cases-----	-----	35,378	100.0	28,835	100.0	6,543	100.0	18.5
Infective and parasitic diseases-----	001-138	7,331	20.8	4,778	16.6	2,553	39.0	34.8
Pulmonary tuberculosis-----	002	5,840	16.5	3,498	12.1	2,342	35.8	40.1
Syphilis and its sequelae ³ -----	020-029	781	2.2	738	2.6	43	.7	5.5
Neoplasms-----	140-239	972	2.7	801	2.8	171	2.6	17.6
Allergic, endocrine system, metabolic and nutritional diseases-----	240-289	573	1.6	498	1.7	75	1.1	13.1
Diabetes mellitus-----	260	501	1.4	440	1.5	61	.9	12.2
Diseases of the blood and blood-forming organs-----	290-299	66	.2	61	.2	5	.1	7.6
Mental, psychoneurotic, and personality disorders-----	300-328	10,634	30.2	9,006	31.3	1,628	24.9	15.3
Psychoses ⁴ -----	300-309	9,647	27.3	8,184	28.4	1,463	22.4	15.2
Diseases of the nervous system and sense organs-----	330-398	4,781	13.5	4,281	14.8	500	7.6	10.5
Vascular lesions affecting central nervous system ⁵ -----	330-334	2,029	5.7	1,881	6.5	148	2.3	7.3
Inflammatory diseases of central nervous system ⁶ -----	340-345	373	1.1	327	1.1	46	.7	12.3
Other diseases of the central nervous system ⁷ -----	350-357	1,156	3.3	1,016	3.5	140	2.1	12.1
Diseases of the circulatory system-----	400-468	6,976	19.7	6,000	20.8	976	14.9	14.0
Arteriosclerotic heart disease, including coronary disease-----	420	4,457	12.6	3,819	13.2	638	9.8	14.3
Hypertensive heart disease-----	440-443	1,076	3.0	980	3.4	96	1.5	8.9
Chronic rheumatic heart disease-----	410-416	575	1.6	482	1.7	93	1.4	16.2
Diseases of the respiratory system-----	470-528	1,338	3.8	1,182	4.1	156	2.4	11.7
Emphysema-----	⁸ 528	918	2.6	813	2.8	105	1.6	11.4

Diseases of the digestive system-----	530-587	442	1.2	343	1.2	99	1.5	22.4
Diseases of the genitourinary system-----	590-637	151	.4	113	.4	38	.6	25.2
Diseases of the skin and cellular tissue-----	690-716	83	.2	64	.2	19	.3	22.9
Diseases of the bones and organs of movement-----	720-749	1,987	5.6	1,668	5.8	319	4.9	16.1
Rheumatoid arthritis and allied conditions-----	722	712	2.0	629	2.2	83	1.3	11.7
Osteoarthritis and allied conditions-----	723	493	1.4	417	1.4	76	1.2	15.4
Congenital malformations-----	750-759	44	.1	40	.1	4	.1	9.1

¹ Excludes 481 childhood disability cases.

² Disease classification based on International Classification of Diseases (1955 revision).

³ Includes syphilis of central nervous system and general paralysis of insane, etc.

⁴ Includes schizophrenic disorders, manic-depressive reaction, involutional melancholia, etc.

⁵ Includes cerebral hemorrhage, cerebral embolism and thrombosis, etc.

⁶ Includes multiple sclerosis, etc.

⁷ Includes paralysis agitans, epilepsy, etc.

⁸ Special modification of international code.

Diseases of the circulatory system-----	400-468	367	133	36.2	6, 143	717	11.7	46	126	27.0
Arteriosclerotic heart disease, including coronary disease-----	420	156	60	38.5	3, 977	482	12.1	324	96	29.6
Hypertensive heart disease-----	440-443	41	9	22.0	965	76	7.8	70	11	15.7
Chronic rheumatic heart disease-----	410-416	110	44	40.0	455	46	10.1	10	3	30.0
Diseases of the respiratory system-----	470-528	76	17	22.4	1, 156	120	10.4	106	19	17.9
Emphysema-----	⁸ 528	43	8	18.6	804	85	10.6	71	12	16.9
Diseases of the digestive system-----	530-587	44	28	63.6	376	65	17.3	22	6	27.3
Diseases of the genitourinary system-----	590-637	28	15	53.6	115	22	19.1	8	1	12.5
Diseases of the skin and cellular tissue-----	690-716	19	7	36.8	61	10	16.4	3	2	66.7
Diseases of the bones and organs of movement-----	720-749	280	87	31.1	1, 605	205	12.8	102	27	26.5
Rheumatoid arthritis and allied conditions-----	722	106	21	19.8	582	57	9.8	24	5	20.8
Osteoarthritis and allied conditions-----	723	17	4	23.5	433	58	13.4	43	14	32.6
Congenital malformations-----	750-759	17	3	17.6	26	0	0	0	0	0

¹ Excludes 481 childhood disability cases.

² Disease classification based on International Classification of Diseases (1955 revision).

³ Includes syphilis of central nervous system and general paralysis of insane, etc.

⁴ Includes schizophrenic disorders, manic-depressive reaction, involutional melancholia, etc.

⁵ Includes cerebral hemorrhage, cerebral embolism and thrombosis, etc.

⁶ Includes multiple sclerosis, etc.

⁷ Includes paralysis agitans, epilepsy, etc.

⁸ Special modification of international code.

Disability freeze and benefit cases only 2]

Type of action and year of onset	All cases		Under 35		35 to 49		50 to 54		55 to 59		60 to 64		65 and over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
CESSATIONS														
All years-----	6,543	100.0	623	100.0	2,084	100.0	1,237	100.0	1,098	100.0	1,180	100.0	301	100.0
1958-----	3	(4)	0	0	2	(4)	1	(4)	0	0	0	0	0	0
1957-----	427	6.6	26	4.2	76	3.7	110	8.8	96	8.7	105	8.9	14	4.7
1956-----	1,354	20.7	90	14.4	281	13.5	278	22.1	312	28.4	337	28.7	56	18.6
1955-----	1,534	23.4	190	30.5	523	25.1	246	19.6	246	22.4	247	20.9	82	27.2
1954-----	1,431	21.9	182	29.2	505	24.2	256	20.4	184	16.8	229	19.4	75	24.9
1953-----	734	11.2	69	11.1	270	13.0	137	10.9	102	9.3	123	10.4	33	11.0
1948-52-----	876	13.4	63	10.1	341	16.4	185	14.7	136	12.4	116	9.8	35	11.6
1941-47-----	184	2.8	3	.5	86	4.1	44	3.5	22	2.0	23	1.9	6	2.0
CONTINUANCES														
All years-----	28,835	100.0	1,454	100.0	6,125	100.0	5,684	100.0	7,073	100.0	7,524	100.0	975	100.0
1958-----	6	(4)	0	0	1	(4)	1	(4)	2	(4)	2	(4)	0	0
1957-----	1,218	4.3	30	2.1	114	1.9	268	4.8	326	4.6	448	6.0	32	3.4
1956-----	6,344	22.0	136	9.4	456	7.4	1,266	22.3	1,916	27.0	2,278	30.2	292	29.9
1955-----	4,915	17.0	235	16.2	665	10.9	978	17.2	1,351	19.1	1,498	19.9	188	19.3
1954-----	3,762	13.0	256	17.6	651	10.6	714	12.6	909	12.9	1,059	14.1	173	17.7
1953-----	2,847	9.9	238	16.4	607	9.9	548	9.6	714	10.1	647	8.6	93	9.5

1948-52-----	6, 979	24. 2	528	36. 2	2, 210	36. 1	1, 378	24. 2	1, 448	20. 5	1, 262	16. 8	153	15. 7
1941-47-----	2, 764	9. 6	31	2. 1	1, 421	23. 2	531	9. 3	407	5. 8	330	4. 4	44	4. 5

¹ Age attained in 1958.

² Excludes 481 childhood disability cases in which 80 were terminated and 401 continued.

³ Investigation of continuing disability based on events occurring before attainment of age 65.

⁴ Less than 0.05 percent.

TABLE AZ.—*Continuing disability determinations: Number and percent of determinations made after field investigation by continuance and cessation and by estimated rate of annual earnings, 1958*

[Disability freeze and benefit cases ¹]

Estimated rate of annual earnings ²	All cases		Continuances		Cessations		Cessations as percent of total
	Number	Percent	Number	Percent	Number	Percent	
Total-----	35, 378	100. 0	28, 835	100. 0	6, 543	100. 0	18. 5
No earnings-----	26, 004	73. 6	25, 118	87. 1	886	13. 5	3. 4
Under \$300-----	98	. 3	79	. 3	19	. 3	19. 4
\$300 to \$599-----	238	. 7	173	. 6	65	1. 0	27. 3
\$600 to \$899-----	290	. 8	147	. 5	143	2. 2	49. 3
\$900 to \$1,199-----	308	. 9	123	. 4	185	2. 8	60. 1
\$1,200 to \$1,799-----	685	1. 9	261	. 9	424	6. 5	61. 9
\$1,800 to \$2,399-----	698	1. 9	228	. 8	470	7. 2	67. 3
\$2,400 and over-----	7, 057	19. 9	2, 706	9. 4	4, 351	66. 5	61. 7

¹ Excludes 481 childhood disability cases.

² Rate of annual earnings estimated by converting weekly wages or net monthly income (for self-employed persons) reported as usual earnings during the period covered by the field investigation of continuing disability into annual amounts. The estimated amount of earnings is based on the assumption that the individual would have continued to work for at least a year and would have continued to earn the same amount throughout the year.

TABLE BA.—Continuing disability determinations: Number of determinations of continuance made after field investigation by nature of work activity, estimated rate of annual earnings, and percentage distribution by reason for continuance, 1958

[Disability freeze and benefit cases only ¹]

Nature of work activity and estimated rate of annual earnings ²	Number of cases	Percentage distribution by reason for continuance			
		Total	Unsuccessful work attempt	Work not substantial gainful activity ³	Other reasons ⁴
Total.....	28, 835				
No work activity.....	25, 118				
Work activity.....	3, 717				
Total work activity cases.....	3, 717	100. 0	60. 2	36. 6	3. 2
Under \$600.....	252	100. 0	34. 1	64. 7	1. 2
\$600 to \$1,199.....	270	100. 0	66. 0	27. 0	7. 0
\$1,200 to \$1,799.....	261	100. 0	72. 4	24. 5	3. 1
\$1,800 to \$2,399.....	228	100. 0	72. 3	22. 4	5. 3
\$2,400 and over.....	2, 706	100. 0	59. 9	37. 3	2. 8
All wage earners.....	3, 152	100. 0	63. 5	33. 6	2. 9
Under \$600.....	186	100. 0	38. 7	60. 2	1. 1
\$600 to \$1,199.....	221	100. 0	71. 0	23. 1	5. 9
\$1,200 to \$1,799.....	230	100. 0	73. 9	23. 5	2. 6
\$1,800 to \$2,399.....	206	100. 0	73. 8	21. 8	4. 4
\$2,400 and over.....	2, 309	100. 0	62. 9	34. 5	2. 6
All self-employed.....	280	100. 0	22. 9	70. 3	6. 8
Under \$600.....	47	100. 0	17. 0	80. 9	2. 1
\$600 to \$1,199.....	29	100. 0	27. 6	58. 6	13. 8
\$1,200 to \$1,799.....	11	(⁵)	(⁵)	(⁵)	(⁵)
\$1,800 to \$2,399.....	5	(⁵)	(⁵)	(⁵)	(⁵)
\$2,400 and over.....	188	100. 0	22. 9	71. 2	5. 9
Nature of work activity unknown.....	285	100. 0	60. 3	36. 5	3. 2
Under \$600.....	19	(⁵)	(⁵)	(⁵)	(⁵)
\$600 to \$1,199.....	20	(⁵)	(⁵)	(⁵)	(⁵)
\$1,200 to \$1,799.....	20	(⁵)	(⁵)	(⁵)	(⁵)
\$1,800 to \$2,399.....	17	(⁵)	(⁵)	(⁵)	(⁵)
\$2,400 and over.....	209	100. 0	60. 3	37. 3	2. 4

¹ Excludes 481 childhood disability cases.

² See footnote 2, table AZ.

³ Includes cases where earnings were from work pursuant to a vocational rehabilitation program or represented termination pay or sick pay, etc.

⁴ Includes statutorily blind persons.

⁵ Number of cases too small for reliable computation.

[Disability freeze and benefit cases only.]

Type of action and occupational group ²	Nature of employer													
	All cases		Self-employed		Family employ- ment		Sheltered work- shop		Government employment		Other private wage employ- ment		Unknown	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
CESSATIONS														
	Total-----	6, 543	100. 0											
	Employed-----	5, 657	86. 5											
	Not employed-----	886	13. 5											
Total employed-----	5, 657	100. 0	223	100. 0	65	100. 0	77	100. 0	301	100. 0	4, 554	100. 0	437	100. 0
Professional and managerial-----	427	7. 5	76	34. 1	2	3. 1	3	3. 9	46	15. 3	296	6. 5	4	0. 9
Clerical and sales-----	1, 142	20. 2	45	20. 2	23	35. 4	19	24. 6	90	29. 9	951	20. 9	14	3. 2
Service occupations-----	1, 106	19. 6	16	7. 2	11	16. 9	16	20. 8	84	27. 9	956	21. 0	23	5. 3
Agriculture, fishing, forestry, etc.-----	132	2. 3	22	9. 9	5	7. 7	1	1. 3	6	2. 0	91	2. 0	7	1. 6
Skilled occupations-----	923	16. 3	36	16. 1	8	12. 3	10	13. 0	21	7. 0	835	18. 3	13	3. 0
Semiskilled occupations-----	821	14. 5	17	7. 6	11	16. 9	11	14. 3	20	6. 6	751	16. 5	11	2. 5
Unskilled occupations-----	524	9. 3	4	1. 8	4	6. 2	9	11. 7	24	8. 0	480	10. 5	3	0. 7
Unknown-----	582	10. 3	7	3. 1	1	1. 5	8	10. 4	10	3. 3	194	4. 3	362	82. 8

[illegible]¹ Excludes 481 childhood disability cases.

² Occupational groups based on classifications used in Dictionary of Occupational Titles, vols. I, II, and supp. I (1949 revision).

PURCHASE OF CONSULTATIVE EXAMINATIONS

TABLE BC.—Total number of disability cases processed by Bureau, number and percent for which consultative medical examinations purchased, and total costs, by quarter, fiscal years 1956-59

[Data in thousands]

Fiscal year and quarter	Total cases processed in Bureau ¹	Medical exams purchased in quarter ²	Percent medical exams of total		Costs for medical exams	
			Quarterly	Cumulative to date	Quarterly	Cumulative to date
1956						
July-December 1955--	96.9	0.3	0.3	0.3	\$5.6	\$5.6
January-March 1956--	72.0	.3	.5	.4	6.2	11.8
April-June 1956-----	85.7	.2	(³)	.3	3.0	14.8
1957						
July-September 1956--	121.0	.3	.2	.2	6.5	21.3
October-December 1956-----	66.5	1.3	2.0	.5	32.1	53.4
January-March 1957--	64.5	3.7	5.7	1.2	90.4	143.8
April-June 1957-----	112.5	8.5	7.6	2.3	198.0	341.8
1958						
July-September 1957--	112.1	13.2	11.7	3.8	294.5	636.3
October-December 1957-----	118.9	17.0	14.3	5.2	413.5	1,049.8
January-March 1958--	136.9	17.4	12.7	6.3	484.3	1,534.1
April-June 1958-----	151.1	20.9	13.8	7.2	613.0	2,147.1
1959						
July-September 1958--	114.8	18.3	15.9	8.1	533.3	2,680.4
October-December 1958-----	124.7	20.1	16.1	8.8	619.1	3,299.5
January-March 1959--	125.6	22.1	17.6	9.6	680.0	3,979.5
April-June 1959-----	149.9	35.5	23.7	10.8	1,130.5	5,110.0

¹ Includes all disability determinations processed or reviewed in Bureau as follows: State and non-State initial cases; State and non-State reconsideration and hearing requests; "attainment" disability insurance benefit cases requiring determination of continuing disability status; and other continuing disability determinations.

² As reported by State agencies.

³ Less than .05 percent.

TABLE BD.—*Number of consultative examinations purchased during fiscal year 1959 by quarter and percent of total disability cases processed by Bureau: Initial determinations, and reconsideration and hearing requests*

Calendar quarter	Initial determinations		Reconsideration and hearing requests	
	Number of consultatives purchased ¹	Percent of total determinations processed ²	Number of consultatives purchased ¹	Percent of total requests processed ³
July–September 1958.....	12, 430	14. 1	4, 720	26. 6
October–December 1958.....	13, 420	14. 5	3, 877	29. 2
January–March 1959.....	14, 060	16. 4	4, 200	29. 4
April–June 1959.....	20, 090	18. 4	5, 940	39. 9

¹ As reported by State agencies.

² Based on total initial disability determinations processed by Bureau, including State determinations reviewed and effectuated by Bureau.

³ Based on total reconsideration and hearing requests on issue of disability, including State determinations reviewed and effectuated by Bureau.

Selected Data on Purchase of Medical Evidence Under the Disability Provisions of the Old-Age, Survivors, and Disability Insurance Program, January–March 1958 ¹

Foreword

INTRODUCTION

The applicant for a disability determination has the responsibility to submit medical evidence, at his own expense, to support his claim. When he has submitted sufficient evidence to show there is a reasonable likelihood that the impairment meets the disability requirements, but there is still some question as to whether a sound decision can be made on the facts, a consultative examination and other medical evidence may be purchased with OASI funds to protect the interests of the Government against an improper allowance. Thus, under appropriate circumstances, a consultative medical examination may be authorized to verify the medical evidence of disability that an applicant has submitted, or to obtain additional clinical details to confirm the diagnosis or establish the severity of the applicant's condition, including the assessment of his remaining capacities for substantial gainful activity or the potential remediability of the condition. Medical evidence may be purchased at the time of initial adjudication, or at the time of reconsideration, hearing, or continuing disability action.

Arrangements to purchase medical evidence are made by the State agencies in accordance with the practices developed by them in administering their regular program. A uniform or fixed procedure for all States is not considered desirable in view of differences in local conditions and varying experiences in medical relationships. The examinations are performed by consulting physicians, generally selected by the State agency medical consultant. The extent to

¹ Source: Bureau of Old-Age and Survivors Insurance, Division of Disability Operations, November 1958.

which the applicant's own physician participates in the selection of the consultant depends upon the policy of the particular State agency. The State agency medical consultant determines the type and scope of evidence to be purchased. The evidence may vary from an abstract of a medical record, to a simple laboratory test, to a complete medical, including specialized tests and studies. In paying for these purchases, the State agency is required to adhere to its established VR fee schedule.

The following tables contain data on the number of cases in which medical evidence has been purchased since the beginning of the OASI disability program, the trend in these purchases, the cost of these purchases, and the medical and demographic characteristics of the cases in which medical evidence is purchased. The data on characteristics are preliminary and were derived from study of a sample of initial determinations only completed in DDO during the first 3 months of 1958. In all cases, the specific type of evidence purchased is shown as reported by State agencies.

SUMMARY OF DATA ON PURCHASE OF MEDICAL EVIDENCE:
SOME HIGHLIGHTS

1. The rate of purchase of consultative examinations has increased.

Fiscal year	Number of examinations purchased	Percent of total deter- minations processed	Total cost (thousands)
1956-----	800	0.3	\$14.8
1957-----	13,800	3.8	327.0
1958-----	68,500	13.2	1,805.3

2. In the July-September 1958 quarter the rate of purchase for reconsideration and hearing cases was almost double that for initial cases.

Type of case	Number of cases pro- cessed in DDO	Number of consultatives purchased	Percent of total
Initial-----	88,100	12,430	14.1
Reconsideration and hearing-----	17,750	4,720	26.6

3. Types of medical evidence purchased in initial cases studied (as reported by State agencies).

Type of evidence	Percent of cases studied
Total.....	100. 0
Medical examination.....	95. 4
General practitioner.....	1. 1
Specialist.....	94. 4
Other evidence.....	51. 9
Medical records.....	2. 7
Laboratory tests and/or X-rays.....	48. 8
Transportation and related expenses.....	. 8

NOTE.—Individual percents not additive. Cases where more than one kind of evidence purchased counted in each classification.

4. Median costs of various specific types of purchased medical evidence.

Type of evidence	Median cost
Total.....	\$26. 5
All medical examinations.....	27. 2
General practitioner examination only.....	8. 3
General practitioner examination and other evidence.....	24. 7
Specialist examination only.....	20. 6
Specialist examination and other evidence.....	33. 7
Other evidence only purchased.....	12. 7
Medical records only.....	6. 3
Laboratory tests and/or X-rays only.....	14. 3

5. Characteristics related to purchase of medical evidence:

(a) For disabled workers, the rate of purchase of medical evidence increased with age. The rate ranged from a low of 1.3 percent of those under age 35 to 12.6 percent of those aged 60-64. The rate of purchase was slightly higher for females than males—9.8 percent and 8.5 percent, respectively, of the cases studied.

(b) These relationships also held true for childhood disability benefit applicants. Medical evidence was purchased in 13.5 percent of the cases age 18-24 and in 24.4 percent of the cases aged 50 and over. Purchases were made for 17.6 percent of the males and 19.9 percent of the females.

(c) The length of time that an individual claimed to be disabled did not seem to be consistently related to the frequency of purchase of evidence. For disabled workers generally, however, the relative frequency of purchase was higher for more recent onsets. This was not true for childhood disability benefit applicants.

(d) Mobility was an important variable related to the rate of purchase of medical evidence. Among disabled workers, the medical evidence was purchased for only 1 percent of the institutionalized workers compared with 11 percent of the workers able to go outside by themselves. The comparable figures for disabled children were 2.4 and 24.6 percent, respectively.

(e) Purchase rates for selected disease groups for disabled workers:

Disease group	Cases with purchased evidence		
	Number	Percent	Percent of total
Total cases, evidence purchased-----	9, 375	100. 0	8. 9
Diseases of the respiratory system-----	1, 598	17. 0	23. 8
Diseases of the circulatory system-----	2, 977	31. 8	11. 0
Diseases of the bone and organs of movement--	1, 661	17. 7	9. 8
Allergic, endocrine, metabolic, and nutritional diseases-----	275	2. 9	8. 5

Together, these four disease groups accounted for close to 70 percent of the cases in which evidence was purchased.

(f) Purchase rates for selected disease groups for disabled children:

Disease group	Cases with purchased evidence		
	Number	Percent	Percent of total
All cases with purchased evidence----	1, 241	100. 0	18. 8
Mental, psychoneurotic, and personality disorders-----	723	58. 3	22. 3
Congenital malformations-----	39	3. 1	18. 1
Diseases of the nervous system and sense organs-----	355	28. 6	16. 5

Together, these three disease groups accounted for 90 percent of the total number of childhood cases in which evidence was purchased.

6. Results of purchase of evidence:

(a) Medical evidence was purchased in 10.8 percent of the cases ultimately allowed compared with 8.1 percent of the cases ultimately denied.

(b) Fifty-two percent of the disabled worker cases in which evidence was purchased were ultimately allowed. This compared with an allowance rate of 46 percent for the cases in which no medical evidence was purchased. For children the same figures were 86 percent and 78 percent, respectively.

PART XI

SUMMARY OF OTHER DISABILITY PROGRAMS

Following are brief outlines of pertinent aspects of Federal disability programs, administered by the Veterans' Administration, the Railroad Retirement Board, and the Civil Service Commission, with special emphasis on the definition of disability and such administrative matters as how evidence of disability is secured and the claimant's rights to appeal. (This material has been prepared from the applicable statutes, regulations, and other published source materials.)

The key differences between the definition used for title II of the Social Security Act and those for the other major Federal programs outlined below are as follows:

A veteran is rated as totally disabled under the veterans' pension and compensation program if his impairment would prevent the average man—rather than the individual himself, as under the Social Security Act—from following a substantially gainful occupation. He may also be found totally disabled even though he does not have a rating of 100 percent disability, provided he is determined to be "individually unemployable." In the pension program, the rating required varies with age, only a 50 percent rating, for example, being required at 60-64.

The national service life insurance disability provisions apply to an individual whose impairments are total and of extended duration but not as long term as required under social security. Under an optional rider in U.S. Government life insurance, the disability similarly need not be of long extended duration. Except for the optional rider, however, the definition of disability for U.S. Government life insurance is quite similar to that of the social security program.

Railroad disability retirement annuities may be paid on the basis of occupational disability if the worker is 60 or over and has 10 years of service, or at any age if he has had 20 years of service with the railroad industry. The railroad retirement definition of "total" disability for nonoccupational disability annuities is similar to that of the social security program.

Civil service disability retirement annuities are based entirely on an occupational concept of disability, under which the disability need only preclude work in the individual's last position.

VETERANS' ADMINISTRATION

DEFINITION OF DISABILITY

The Veterans' Administration administers several programs in which disability is a factor, including pension for non-service-connected disability, compensation for service-connected disability, and life insurance for veterans.

1. Pension

The statute provides for a pension to be paid, subject to an annual income limitation, to each veteran who had the requisite wartime service "who is permanently and totally disabled from non-service-connected disability not the result of the veteran's willful misconduct or vicious habits * * *" (38 U.S.C. 521). A person is considered to be totally and permanently disabled if he is suffering from—

(1) Any disability which is sufficient to render it impossible for the average person to follow a substantially gainful occupation, but only if it is reasonably certain that such disability will continue throughout the life of the disabled person; or (2) any disease or disorder determined by the Administrator to be of such a nature or extent as to justify a determination that persons suffering therefrom are permanently and totally disabled (38 U.S.C. 502).

The Veterans' Administration regulations provide for use of a rating schedule in determining disability, allowances of pension being made where a rating of total disability can be assigned through application of the provisions in the schedule, provided permanence is established. The administrator is authorized to readjust the schedule of ratings in accordance with experience.¹

With regard to the application of this rating schedule, a determination of permanent total disability is possible under certain conditions even though the disability is rated at less than 100 percent. This is explained as follows in the recent report on H.R. 7650 by the Committee on Veterans' Affairs of the House of Representatives (H. Rept. 537, 86th Cong., 1st sess., p. 11):

In the administration of the aforementioned provisions the determination of permanent total disability is made on a very liberal basis. Such a rating is granted (where the requirement of permanence is met) when there is a single disability of 60 percent or two or more disabilities one of which is 40 percent in degree, combined with other disability or disabilities to a total of 70 percent, and unemployability attributed thereto. Although age alone is not considered as a basis for entitlement to such pension, it is considered in association with disability and unemployability in determining permanent and total disability. The aforementioned percentage requirements are reduced on the attainment of age 55 to a 60 percent rating for one or more disabilities, with no percentage requirement for any one disability; at age 60 to a 50 percent rating for one or more disabilities; and at age 65 to one disability ratable at 10 percent or more. When these reduced percentage requirements are met and the disability or disabilities involved are of a permanent nature, a permanent and total disability rating will be assigned, if the veteran is determined to be unable to secure and follow substantially gainful employment by reason of such disability.

2. Compensation

Compensation is payable—

for disability resulting from personal injury suffered or disease contracted in line of duty, or for aggravation of a preexisting injury suffered or disease contracted in line of duty—

unless it results from the veteran's own misconduct (38 U.S.C. 310, 331).

To determine disability, the Veterans' Administration uses the rating schedule which lists impairments in 11 grades ranging from 0 percent disability upward in 10 percent steps to a rating of 100 percent disability. These percentages of disability are assigned to reflect so far as practicable the extent to which the impairment would reduce the earning capacity of the average person in civilian employ-

¹ At present the Veterans' Administration uses the Schedule for Rating Disabilities, 1945 edition (38 CFR 3.148)

ment. A total disability rating may also be assigned where the disability is less than 100 percent in certain instances of unemployment similar to the rules on pension (see paragraph quoted from H. Rept. 537, in item 1, above), except that age is not a factor. The ratings for an individual may be modified in exceptional cases, when the percentages assigned under the rating schedule are excessive or inadequate. For purposes of service-connected benefits (compensation), the disability need not be a permanent one.

3. Insurance

(a) U.S. Government life insurance (for persons in service during World War I or thereafter to October 8, 1940, and veterans of World War I until April 25, 1951) provides benefits for death or permanent and total disability. Aside from certain statutory disabilities, the law contains no definition of "permanent and total" disability. Under the Veterans' Administration regulation, it is defined as—

any impairment of mind or body which continuously renders it impossible for the disabled person to follow any substantially gainful occupation and which is founded upon conditions which render it reasonably certain that the total disability will continue throughout the life of the disabled person (38 CFR 6.121).

Under an optional rider, benefits are provided for extended total disability after a waiting period of 4 months. A few contracts issued prior to 1930 provide for a waiting period of 12 months. For the purposes of these riders, the disability need not be permanent.

(b) National service life insurance (insurance policies issued after October 7, 1940) provides for waiver of premiums under certain conditions during periods of total disability which continue for six or more consecutive months (38 U.S.C. 712). Under an optional rider, monthly benefits are provided for extended total disability after a waiting period of 6 consecutive months (38 U.S.C. 715). Benefits are payable beginning with the seventh month of disability. The disability need not be permanent. The regulations define "total disability" for purposes of these policies as "any impairment of mind or body which continuously renders it impossible for the insured to follow any substantially gainful occupation" (38 CFR 8.43(a)).

ADMINISTRATION

1. Determination of disability

(a) *Pension and compensation.*—The adjudication of claims for pension or compensation is generally performed in the adjudication division of the Veterans' Administration regional office or other facility. With respect to the issue of disability, however, the Administration has set up rating boards which are vested with authority to determine and evaluate disability, to determine the necessity for and type and sufficiency of medical examinations and reexaminations and to determine questions of service connection. The usual composition of the rating board is a medical specialist, an occupational specialist, and a legal specialist.

The Veterans' Administration regulations provide that in connection with claims for disability compensation and pension—

an examination will not be authorized unless and until evidence is on record, either from the service departments, or in the form of certified statements, indi-

cating the reasonable probability of a valid claim * * *. Where the claimant appears in person and preliminary inquiry establishes the reasonable probability of a valid claim, an immediate physical examination may be requested * * * (38 CFR 3.76).

A disability rating may not generally be made in the absence of an official Veterans' Administration examination. However, if a claim is filed within 6 months from the date of separation from service, it may be rated initially on the basis of the records of the service department. Reexamination is then scheduled with an official Veterans' Administration examiner. Reexaminations are usually performed by Veterans' Administration examiners and at the cost of the Veterans' Administration. They are authorized, in general, in cases in which it is indicated that—

there has been a material decrease in disability since the last examination and in cases where there is evidence * * * that the disability is likely to improve materially in the future (38 CFR 3.185).

Static disabilities need not be reexamined. In cases of veterans of World War I and other veterans 55 years of age or older, a second reexamination is requested only in the most unusual cases.

(b) *Insurance.*—Determinations and evaluation of disability for insurance purposes are generally made by the disability insurance claims division in the three field stations of the Department of Insurance of the Veterans' Administration.

In support of claims for insurance, the Veterans' Administration regulations provide that the applicant may be requested to submit statements and—

additional information concerning his industrial activities and physical and mental condition as may be required by the Veterans' Administration (38 CFR 6.202).

The regulations further provide with respect to U.S. Government life insurance that—

it is deemed necessary * * * to require a physical examination by a * * * physician at a field station of the Veterans' Administration * * * (1) when an application has been filed * * * for payment of insurance benefits on account of total or total and permanent disability unless in accordance with prescribed insurance procedure a physical examination is not necessary; (2) when requested * * * for the purpose of review * * * of claims in which insurance benefits are being paid, to determine if the person has recovered the ability to follow a gainful occupation (38 CFR 6.90).

With respect to national service life insurance, physical examination in connection with a claim for total disability—

may be made by a medical officer of the U.S. Army, Navy, or Public Health Service, or may be made at Government expense by a * * * physician at a regional office or hospital of the Veterans' Administration (38 CFR 8.65).

Generally, the Veterans' Administration has broad latitude in deciding whether and when to authorize a physical examination at Veterans' Administration expense.

2. *Appeals process*

By statute, all questions on claims involving benefits under the laws administered by the Veterans' Administration are subject to one review on appeal to the Administrator, this function being carried out by a Board of Veterans' Appeals whose members are appointed by the Administrator with the President's approval. The Board is bound in its decisions by the regulations of the Veterans' Adminis-

tration, instructions of the Administrator, and the precedent opinions of the chief law officer. Its decisions are final in claims for benefits other than insurance, and not subject to further review by the courts or other Government officials.

In connection with the appeal, Veterans' Administration procedures provide that the claimant may elect to appear for a formal hearing, with representation, which may be held before sections of the Board of Veterans' Appeals in central office, before a traveling section of the Board when in session in a field office or before a rating board or other adjudicating agency which rendered the decision from which appeal is taken, acting as a hearing agency for the Board. The hearing is primarily for the purpose of receiving the contentions and oral argument of the claimant. A complete transcript of the hearing record is included in the file and, unless the appeal is withdrawn, is certified to the Board of Veterans' Appeals for decision.

Where there is disagreement on a claim for insurance (national service life insurance, U.S. Government life insurance) the law provides that action may be brought in the appropriate Federal district court, with appellate jurisdiction exercised by the courts of appeals. The insured may bring such action whether or not he has taken advantage of his right to appeal to the Board of Veterans' Appeals.

The Veterans' Administration appeals process is not subject to the requirements of the Administrative Procedure Act pertaining to adjudication of claims and the conduct of hearings thereon, since those provisions do not apply in the absence of a specific statutory requirement for determination on the record after opportunity for an agency hearing.

RAILROAD RETIREMENT ACT

DEFINITION OF DISABILITY

Under the Railroad Retirement Act, there are two types of benefits payable to workers on account of disability. Permanent total disability annuities may be payable to workers who have had at least 10 years of service with the railroad industry and "whose permanent physical or mental condition is such that they are unable to engage in any regular employment" (45 U.S.C.A. 228b(a)5). Occupational disability annuities may be payable to workers—

having a current connection with the railroad industry, and whose permanent physical or mental condition is such as to be disabling for work in their regular occupation, and who (i) will have completed twenty years of service or (ii) will have attained the age of sixty—

and have at least 10 years of service (45 U.S.C.A. 228b(a)4). In addition, a child aged 18 or over of a deceased worker may qualify for survivors' monthly benefits if he has "a permanent physical or mental condition which is such that he is unable to engage in any regular employment," provided such disability began before he was 18 (45 U.S.C.A. 228e(1)(1)(ii)).

A worker qualifies as permanently and totally disabled—

if his physical or mental condition is such that he is unable to perform regularly, in the usual and customary manner, the substantial and material duties of any regular and gainful employment which is substantial and not trifling, with any employer, whether or not subject to the act, and the facts of his physical or mental condition afford a reasonable basis for an inference that such condition is permanent (20 CFR 208.17).

An annuity based on occupational disability is payable to an employee whose physical or mental condition is such as to disable him permanently for work in his "regular occupation" according to standards developed by the Railroad Retirement Board in cooperation with representatives of employers and employees. The law specifies—

an individual's condition shall be deemed to be disabling for work in his regular occupation if he will have been disqualified by his employer because of disability for service in his regular occupation in accordance with the applicable standards so established; if the employee will not have been so disqualified by his employer, the Board shall determine whether his condition is disabling for work in his regular occupation in accordance with the standards generally established; and, if the employee's regular occupation is not one with respect to which standards will have been established, the standards relating to a reasonably comparable occupation shall be used (45 U.S.C.A. 228b(a)4).

ADMINISTRATION

1. Determination of disability

Claims for disability annuity are adjudicated in the Railroad Retirement Board's central Bureau of Retirement Claims. The determination of the existence and extent of disability is made within that Bureau by personnel selected for that purpose.

The individual is required to submit to any examinations designated by the Board as proof, initially, of the disability and, thereafter, of the continuance of such disability to age 65. The Board's instructions provide that a case will not knowingly be rated solely on the basis of medical evidence furnished by the applicant's personal physician.

The following sources of medical evidence are drawn upon in making determinations of disability:

(a) Medical evidence from employee's attending physician, generally submitted when application is filed, and paid for by the applicant.

(b) Railroad Retirement Board employers: Most railroads maintain medical departments. From 50 to 60 percent of all medical evidence is obtained from this source, without charge. This is frequently the only source used in occupational disability cases.

(c) Designated medical examiners: In cooperation with the American Medical Association, the Railroad Retirement Board has established local listings of physicians to whom applicants are referred for supplemental evidence, when necessary. The Board pays for these examinations according to fixed schedules of reimbursement. There is also a list of specialists reimbursed by the Board under variable schedules.

(d) Veterans' Administration facilities: The Railroad Retirement Board has arranged with the Veterans' Administration to obtain without charge medical evidence available at any Veterans' Administration facility. When necessary, and if convenient to the applicant, the Veterans' Administration provides specialists' examinations at Veterans' Administration facilities, which are paid for by the Railroad Retirement Board.

(e) Railroad hospital associations: Railroad employers and employees have many hospital associations which provide medical

facilities for contributing members and furnish any medical information available, without charge, to the Railroad Retirement Board.

(f) Other sources: Where information can be obtained without charge, the Railroad Retirement Board secures medical evidence from Federal, State, and municipal hospitals. If the applicant has filed for disability benefits under title II of the Social Security Act, such medical evidence as is available in the files of the Bureau of Old-Age and Survivors Insurance may be furnished the Board.

Periodic reexaminations may be required when there is a question of continuing disability. The Railroad Retirement Board secures medical evidence from appropriate sources without cost to the annuitant.

2. Appeals process

Under the law, a claimant has the right to appeal to the Railroad Retirement Board on any decision made in a claim for disability annuity (45 U.S.C.A. 228j(b)(5)). After exhausting his administrative remedies, any party not satisfied with the Board's decision may apply for a review of the case on the record to a U.S. circuit court of appeals (45 U.S.C.A. 228k, 355(f)).

By regulation, the Board has established an Appeals Council, consisting of a chairman and two members, to hear and determine appeals from initial decisions made by the Bureau of Retirement Claims. The appellant may request an oral hearing and present further evidence or arguments. The Council may on its own secure additional evidence and take testimony. Oral proceedings are informal but a complete written record must be kept. The decision is made by agreement of two or more members of the Council, and is subject to review by the Board at the appellant's request.

The proceedings of the Railroad Retirement Board are not subject to the Administrative Procedure Act, since the Board is exempt from that act as an agency "composed of representatives of the parties or of representatives of organizations of the parties to the disputes determined" by it (Administrative Procedure Act, sec. 2a; 5 U.S.C. 1001).

CIVIL SERVICE RETIREMENT ACT

DEFINITION OF DISABILITY

The Civil Service Retirement Act provides for retirement on an annuity of any employee with 5 years of civilian service who is found by the Civil Service Commission to have become disabled. The term "disabled" is defined as—

totally disabled for useful and efficient service in the grade or class of position last occupied by the employee * * * by reason of disease or injury not due to vicious habits, intemperance, or willful misconduct on his part within the 5 years next prior to becoming so disabled (5 U.S.C.A. 2251(g), 2257(a)).

The annuity to an annuitant found recovered or restored to earning capacity before age 60 is discontinued at the end of the month preceding the earliest of the following:

1. Date of reemployment by the Government.
2. One year from the date of a medical examination showing recovery.

3. One year from the date of determination that the person's earning capacity is restored.

ADMINISTRATION

1. Determination of disability

When a civil service employee applies for disability retirement, a statement by his attending physician is required. The employing agency assists the employee by furnishing report forms for the physician's use, but the employee must see that the statement is submitted and pay any fee incurred.

Where a Federal medical officer and adequate medical facilities are readily available to the employing agency, arrangements are made for medical examination of the employee. Otherwise the Commission in Washington or the appropriate regional medical office of the Commission makes arrangements for a medical examination by a Federal medical officer or other designated physician.

In every case, the file must contain a statement of the employee's superior officer. The statement outlines the duties of the job and describes in detail the effect applicant's disability has on his performance of these duties. Great weight is usually given to this statement.

Final determination in each case is made in the Commission's central office, Washington, D.C., and is based on the opinions and conclusions of one or more medical officers depending on (1) the complexity of the case and the nature of the points to be resolved, and (2) whether the individual signed the application himself or if it was submitted by the agency where he is employed.

In cases where the regional medical officer arranges for the examination, he forwards the report to the central office in Washington, D.C., with his recommendation for denial or allowance. The file is reviewed by a medical officer in the central office and if he concurs with the recommendation the case is acted upon accordingly. If he disagrees, the final decision is based on the consensus of opinion of the medical officers reviewing it. The medical officers of the Commission's central office also evaluate the merits (after securing any required medical evidence) of all other cases where a regional medical officer has not been initially involved.

Unless the Commission determines that his disability is permanent in character, a disability annuitant is subject to annual medical examinations until he reaches age 60. The annuitant is sent a questionnaire to complete and asked to obtain a current statement of his condition from his attending physician, if he can do so without expense to himself. If he cannot obtain such a report, the Commission arranges for an examination at no expense to the individual. An annuity may be suspended if an annuitant fails to submit to these examinations.

2. Appeals process

The Civil Service Retirement Act provides that an appeal to the Civil Service Commission shall lie from any administrative decision under that act (5 U.S.C.A. 2266(d)). The law further specifies that decisions of the Commission on issues of dependency and disability are final and are not subject to review.

The Commission's Board of Appeals and Review acts on appeals from decisions by the Retirement Division. While there is no specific provision in the regulations for it, the Board may grant a hearing in its discretion. Generally, however, all proceedings are in writing. The decision of the Board of Appeals and Review is the final administrative decision in the case. Although the law does not specifically provide for it, it has been held that such decisions may be subject to review in the Federal courts.²

Since there is no specific statutory requirement for determination on the record after opportunity for an agency hearing, these appeals proceedings are not subject to the requirements of the Administrative Procedure Act pertaining to adjudication of claims and the conduct of hearings thereon.

² See *Dismuke v. U. S.*, 297 U.S. 167, 56 S. Ct. 400 (1936).



[CONFIDENTIAL COMMITTEE PRINT]

SAMPLE DISABILITY SURVEY

PREPARED BY PERSONNEL OF THE
GENERAL ACCOUNTING OFFICE

UNDER DIRECTION OF THE
SUBCOMMITTEE STAFF

AT THE REQUEST OF THE
SUBCOMMITTEE ON ADMINISTRATION OF THE
SOCIAL SECURITY LAWS

OF THE
WAYS AND MEANS COMMITTEE
HOUSE OF REPRESENTATIVES

DECEMBER 1959-JANUARY 1960



NOTE.—This survey is published for information. It has not been approved or disapproved by either the Subcommittee on Administration of the Social Security Laws or the Committee on Ways and Means, or any member thereof.

COMMITTEE ON WAYS AND MEANS

WILBUR D. MILLS, Arkansas, *Chairman*

AIME J. FORAND, Rhode Island	RICHARD M. SIMPSON, ¹ Pennsylvania
CECIL R. KING, California	NOAH M. MASON, Illinois
THOMAS J. O'BRIEN, Illinois	JOHN W. BYRNES, Wisconsin
HALE BOGGS, Louisiana	HOWARD H. BAKER, Tennessee
EUGENE J. KEOGH, New York	THOMAS B. CURTIS, Missouri
BURR P. HARRISON, Virginia	VICTOR A. KNOX, Michigan
FRANK M. KARSTEN, Missouri	JAMES B. UTT, California
A. S. HERLONG, Jr., Florida	JACKSON E. BETTS, Ohio
FRANK IKARD, Texas	BRUCE ALGER, Texas
THADDEUS M. MACHROWICZ, Michigan	ALBERT H. BOSCH, New York
JAMES B. FRAZLER, Jr., Tennessee	JOHN A. LAFORE, Jr., ² Pennsylvania
WILLIAM J. GREEN, Jr., Pennsylvania	
JOHN C. WATTS, Kentucky	
LEE METCALF, Montana	

LEO H. IRWIN, *Chief Counsel*

JOHN M. MARTIN, Jr., *Assistant Chief Counsel*

THOMAS A. MARTIN, *Minority Counsel*

GERARD M. BRANNON, *Professional Staff*

RAYMOND F. CONKLING, *Professional Staff*

SUBCOMMITTEE ON ADMINISTRATION OF THE SOCIAL SECURITY LAWS³

BURR P. HARRISON, Virginia, *Chairman*

A. S. HERLONG, Jr., Florida	THOMAS B. CURTIS, Missouri
WILLIAM J. GREEN, Jr., Pennsylvania	JACKSON E. BETTS, Ohio
JOHN C. WATTS, Kentucky	ALBERT H. BOSCH, New York
LEE METCALF, Montana	

FREDERICK B. ARNER, *Subcommittee Counsel*⁴

¹ Died Jan. 7, 1960.

² Appointed Jan. 18, 1960.

³ For resolutions relating to subcommittees, see H. Res. 182, 206.

⁴ On loan from the Legislative Reference Service, Library of Congress.

CONTENTS

	Page
General comments.....	1
Summary of disability survey findings:	
Experience of disability applicants with the Social Security district offices.....	2
Views of initially denied applicants as to denial letter and appeal....	3
Experience of applicants denied by referees of the Social Security Appeals Council.....	3
Views of doctors and hospital officials as to medical evidence furnished disability applicants.....	4
Doctors' views as to whether the patient or the Government should pay for medical examinations and reports.....	5
Criticism of social security medical reports.....	5
Experience of doctors with Social Security or State agency personnel..	6
Interview reports:	
Doctors.....	7
Hospital officials.....	55
Applicants receiving benefits.....	64
Denied applicants.....	105
Applicants denied after hearing.....	162
The disability insurance program—Brief history and summary.....	212

DISABILITY SURVEY REPORT

GENERAL COMMENTS

During December 1959 and January 1960, the staff members of the U.S. General Accounting Office (GAO) assigned to the House Subcommittee on Administration of the Social Security Laws, Committee on Ways and Means, made a survey of disability applicants, doctors, and hospital officials. The purpose of this survey was to secure information on how the American citizen feels he was treated under the social security disability program, and to obtain the benefit of the views and experience of doctors and hospital officials who supply medical evidence for disability applicants.

Due to the cost factors involved, only a limited random sample was possible. The sample taken was selected on a broad basis so as to reflect the views of representative individuals who had come in contact with the program.

Social security disability applicants who applied recently and resided within a 100-mile radius of Baltimore, Chicago, Kansas City, New York, Philadelphia, and San Francisco were selected. Twenty-five applicants, both allowed and denied benefits, and 15 doctors or hospital officials were interviewed in each of these six areas. The disability applicants gave their impressions of the service and assistance received from the Social Security district offices and their experiences with hearing examiners in appeal cases. Doctors and hospital officials gave us their views relative to furnishing medical evidence for social security applicants and other aspects of the social security disability program.

The names of individuals interviewed—disability applicants, doctors, and hospital administrators—are, for obvious reasons, not divulged herein. This survey is published solely for informational purposes. The opinions expressed in this document, either individually or in summary form, have not been approved or disapproved by either the members of the subcommittee or full Committee on Ways and Means or the staff.

The following survey summary and narrative interview sheets were prepared by the GAO staff assigned to the subcommittee under the direction of the subcommittee counsel.

SUMMARY OF DISABILITY SURVEY FINDINGS

Experience of disability applicants with the Social Security district offices

Most of the disability applicants interviewed had to wait only a short time at the Social Security district offices for service and all but 6 of 151 applicants said that they were treated in a courteous manner.

Fifty-seven of 151 applicants did not feel that the Social Security representatives fully explained the disability program and their rights under it. Only 60 of 151 applicants could recall being given any explanation as to how disabled they had to be in order to get benefits. This explanation was generally limited to a few words—e.g., the applicant was told his disability had to be sufficiently severe to prevent him from doing any substantial work. Only 9 of 56 applicants, whose initial claims were denied and had not appealed, returned to the Social Security district offices for an explanation of their denials.

Very few of the disability applicants were engaged in any work activity—only 18 of 151 applicants reported that they were doing some work. The survey results show:

	Number of applicants	
	Engaged in some work activity	Not working
Applicants receiving benefits.....	2	52
Applicants denied benefits.....	16	81
Total.....	18	133

The disability applicants were asked from what source they first learned about the disability program. The applicants' answers were summarized as follows:

Found out about disability program from—	Number of applicants
Radio, television, and newspapers.....	45
Relatives or friends.....	35
City, State, or Federal agencies.....	24
Doctors or hospitals.....	18
Employers.....	12
Unions.....	7
No answer or not classified above.....	10
Total applicants interviewed.....	151

Thirteen of the one hundred and fifty-one applicants were visited by Social Security representatives—the others went to the Social Security district offices or contact stations to file their claims. Only 5 of 151 applicants thought that the Social Security representative

attempted to discourage them from filing a claim—4 of these applicants were subsequently denied.

Views of initially denied applicants as to denial letter and appeal

Most of the applicants commenting on the social security denial letter said that it was too general and did not adequately explain the reason the claim was denied.

The initially denied applicants were asked what further action, if any, they planned. Twelve of fifty-six applicants whose initial claims for benefits were denied intend to appeal their denials. Twenty of fifty-six denied applicants believe that the requirements for a disability benefit are too severe or are discouraged and feel it would be a waste of time to appeal. The applicants' answers were summarized as follows:

Applicants reaction to initial denial:	Number of applicants
Applicant satisfied the denial was proper.....	7
Applicant is not aware of his appeal rights or confused as to how to proceed.....	4
Applicant believes the requirements for a disability benefit are too severe. Made a comment such as "you must be nearly dead to qualify for disability benefits".....	8
Applicant is discouraged and feels it would be a waste of time to appeal.....	12
The applicant intends to appeal his case.....	12
No answer or not able to classify above.....	13
Total initially denied applicants interviewed.....	56

Experience of applicants denied by referees of the Social Security Appeals Council

A person who is dissatisfied can have his case reviewed by a referee of the Social Security Administration's Office of Hearing and Appeals (Appeals Council). The referee can, under the law, reverse the finding of either the State agency or the Bureau. If the decision is against the claimant he may request the Appeals Council to review the case and the Council may do so at its discretion. As a matter of procedure, the Council will generally decline formal review if examination of the case shows that formal review would not be of any advantage to the appellant. The Council is empowered to reverse the referee on the appeal of the applicant or on its own motion. After the administrative remedies have been exhausted the individual may bring an action to review the determination in the U.S. district court in the judicial district in which he lives.

Thirty-six applicants who were denied by a referee of the Social Security Appeals Council were interviewed to get their views of their experience with the disability program. Six of the thirty-six applicants denied after a hearing said that they were not informed of their right to submit additional evidence prior to the hearing. Thirteen of thirty-six applicants stated that they were not told that they could have someone represent them at the hearing. Thirty-two of thirty-six applicants attended the hearing but only nine had someone represent them. Only 3 of the 32 applicants who attended the hearings felt that the hearing examiners were discourteous. All 36 applicants were

asked whether they were satisfied that they got a fair hearing. We summarized their answers as follows:

	<i>Number of applicants</i>
Applicant satisfied he got a fair hearing.....	24
Applicant not satisfied he got a fair hearing.....	8
No answer.....	4
Total applicants denied after hearing.....	36

These denied applicants were asked what further action, if any, they planned to take. Their answers are summarized as follows:

	<i>Number of applicants</i>
Applicants reaction to denial after hearing:	
Applicant satisfied with the referee's decision.....	8
Applicant has requested the Appeal Council to review his case.....	8
Applicant did not know of his further appeal rights.....	10
Applicant knew of his appeal rights but decided not to take further action.....	10
Total applicants denied after a hearing interview.....	36

Ten of 36 applicants denied after a hearing were unaware that they had any further appeal rights. Ten applicants seemed aware of their appeal rights but decided not to take further action. Seven of the 10 made this decision because they believed action would be too costly, take too long, or be futile.

Views of doctors and hospital officials as to medical evidence furnished disability applicants

The Social Security district office is the point of original contact for all applicants for a disability benefit. A member of the district office staff interviews the applicant in order to secure from him basic information about the nature and extent of his impairment, the way it limits his daily activities and his ability to work, the medical treatment he has received, his education, work experience, and other facts pertinent to a disability claim. The applicant is then asked to provide one or more reports from the doctors who are treating him or from hospitals or Government agencies that may have examined him. The local district office provides the applicant with one or more report forms which he either takes or mails to his doctor for completion. The doctor may use the social security medical report or furnish the information in any convenient form such as a narrative summary, or a photocopy of his records. The doctor is asked to provide an adequate summary of the history, diagnosis, physical and clinical findings, treatment and response, so that a reviewing physician may evaluate the severity of the condition and the limitations upon the applicant.

In interviews with doctors and hospital officials information was sought as to the amount of burden placed on them by the Social Security Administration in providing disability applicants with medical evidence. They were asked if they had any criticism of the social security medical reports, and whether the patient should be given a current medical examination before being provided a medical report. Their views were obtained as to whether the Government or the patient should pay for the costs of medical examinations and preparation of medical reports.

Doctors' views as to whether the patient or the Government should pay for medical examinations and reports

Most of the doctors and hospital officials believe that the patient, rather than the Government, should pay for medical examinations and the preparation of medical reports. The results based on interviews with 91 doctors and hospital officials were:

	Doctor favors payment from—			
	Patient	Government	Did not specify	No payment desired
Medical examinations.....	53	22	3	
Medical report.....	36	24	3	15
	Hospital official favors payment from—			
	Patient	Government	Did not specify	No payment desired
Medical examinations.....	5	3	5	
Medical report.....	3	4		6

Major reasons given by those respondents who favor payment by the patients were: (1) the burden should be placed on the applicants so as to discourage those who know they cannot qualify; (2) the patient should pay because he is the one receiving benefits; (3) the examination brings to light current maladies and the opportunity for treatment thereby directly benefits the patient; and (4) the patient, in choosing the doctor, has established a private relationship between the doctor and himself. The physicians and hospital officials favoring payment by the Government gave as their major reasons the fact that (1) disabled applicants cannot generally pay for the costs involved and (2) the Government should pay since it is seeking the information. A few respondents took the position that the Government should pay only if the patient is financially unable to do so.

Criticism of social security medical reports

Thirty-four of ninety-one doctors and hospital officials interviewed were critical of the social security medical reports. Generally they commented that it was not specific enough as to the kind and extent of the information wanted, and that there is not enough space after some of the questions for the doctor to record and explain his findings. Twenty-two of the doctors praised the report generally, stating that the social security medical report was very clear and concise. Thirty-five of the doctors and hospital officials did not make any comments about the social security medical report, but stated they had no criticism. A few doctors commented that the social security medical report calls for tests which the average doctor is not equipped to perform in his office. Some doctors indicated that they resent receiving requests for additional information after furnishing a medical report, and others resent receiving social security medical reports through the mail. A few doctors said that requests for medical evidence are sent to several doctors or hospitals when one medical source would be sufficient—about one-fourth of the applicants who personally took medical reports to doctors and hospitals secured a medical report from more than one doctor or hospital. Many additional medical reports for these applicants were secured by the Social Security district office or the applicant by mail.

Sixty-nine of the ninety-one doctors and hospital officials interviewed furnish less than four medical reports monthly for disability applicants. Nearly all the doctors said it takes less than 1 hour to complete a social security medical report. Most doctors, except where they have recently examined the patient, prefer giving the applicant a current examination prior to completing the medical report. A majority of the doctors stated that they did not need additional guidance as to the kind of medical information to be furnished with social security claims.

Experience of doctors with Social Security or State agency personnel

Most of the doctors interviewed had little contact with either Social Security or State agency personnel. Seventy-five of the ninety-one doctors and hospital officials interviewed did not have any criticism of their relations with the State agency or Social Security representatives. Nine doctors praised the existing cordial relations with Social Security or State agency personnel. A few doctors praised the performance of these groups. One doctor said that in his relations with State employees he has found them to be realistic in their approach and attitude.

Six doctors were critical of Social Security or State agency personnel.

INTERVIEW REPORTS

GENERAL COMMENTS

The General Accounting Office representatives took notes during the interviews to assist them in the completion of the interview reports. The reports were prepared promptly after the interviews and although generally they did not attempt to quote the applicants or doctors directly, every effort was made to report their views accurately. All names have been deleted in accordance with the subcommittee's assurance that no names would be divulged as the source of any of the information reported.

DOCTORS

INTERVIEW WITH DOCTOR

I was able to arrange an appointment with Dr. ——— on December 9, 1959. He recalled filling out one medical report for social security but doubted seriously whether he ever prepared more than this one. Dr. ——— stated he gave up his general practice approximately 5 years ago and concentrated on surgery. This he believes is the reason he has had little cause to use this type of report. He estimates a half hour would be sufficient to complete the form.

Dr. ——— feels a current medical examination or reexamination should be given in all cases before providing a medical report. The doctor also feels he should be compensated for filling out medical reports for his patients and the patients should pay the fees if they are financially able. Dr. ——— remarked that probably the majority of these disabled persons would not have funds to pay the fees, but he cannot see any reason why the Government should bear the cost.

The doctor had no criticism of his dealings with the Social Security representatives since they had been practically nil, but he stated he thought the medical report form was a good one, very clear and concise.

Dr. ——— seemed very vague concerning various aspects of the disability program, its relation with the State vocational rehabilitation agencies, age requirements of the applicants and many other aspects. He believes the program, what little knowledge he has of it, to be a wonderful thing, certainly progress in the right direction.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed on December 11, 1959, at his office. Dr. ——— offered as much of his time as was necessary for the interview and was very cooperative.

Dr. ——— said he had not received any requests during the month of November to furnish medical reports for social security disability

applicants. He said he averages about five or six a year. He said the average length of time required by him to prepare a medical report for a social security disability applicant is from 30 to 60 minutes.

He had no criticism of the medical reports required in connection with social security claims. Dr. ——— said he feels that he should always give the patient a current examination before providing a medical report.

Dr. ——— said he believes he should be compensated for filling out a medical report form for his patients. He said the patient should pay, mainly because it would deter patients without severe impairments from filing. He also said that he believes the patient should pay for a current medical examination.

Dr. ——— said that he never had any contacts with either Social Security representatives or State vocational rehabilitation employees.

He feels that he has been furnished adequate information as to the kind of medical information that was necessary in preparing medical reports for social security disability applicants.

Dr. ——— had no other comments on the social security disability program but he did say the intricacies of the social security operations are not familiar to him except insofar as it pertains to patients' eligibility.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I met with Dr. ——— on December 29, 1959. He receives about one request a month for medical reports from disability applicants. It takes the doctor from 10 to 20 minutes to complete the report where a physical examination is not necessary. He had no criticism about the present medical report form.

Dr. ——— stated that if a patient has not been examined by him within the past 3 months, he requires an examination before completing the report. The doctor does not charge his patients for filling out a medical report when an examination is not required. When a physical examination is necessary in connection with the medical report the doctor feels that the patient should bear the cost of the examination as he is the one attempting to prove he is disabled.

The doctor has no criticism of his dealings with representatives of Social Security and the State vocational rehabilitation agency. He did comment that he believes a good screening of applicants by Social Security representatives is needed before the applicant is requested to furnish a medical report. He stated that too many people with minor complaints come to him with medical report forms and that they have no serious or permanent disability and could never be entitled to disability benefits.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— on December 21, 1959. He received two requests during the last month to furnish medical reports for social security disability applicants. It takes the doctor and his secretary each about 20 minutes to prepare the report. The only criticism of the report the doctor had was that the form does not provide enough

space to answer some of the questions. He generally has to attach a narrative supplement.

Dr. ——— feels that he should always give the patient a current examination before providing a medical report. He stated, however, that in actual practice he does not always do this. He sometimes is called upon to render a report for applicants that he has not examined for a long time.

The doctor stated he did not charge for either a medical examination or for filling out the medical report, when it is for a social security disability claim. The doctor gave examinations and prepared reports only for applicants who already were his patients. He favors the Government paying a nominal charge for the social security medical reports. He does not think the applicants should have to pay for these reports since most of them cannot afford it.

Dr. ——— had no criticism of his dealings with either the Social Security representatives or the State vocational rehabilitation employees. He felt he had been furnished adequate information as to what medical information was desired in connection with social security disability claims.

Dr. ——— was of the opinion something should be done about applicants who are capable of engaging in substantial gainful employment and therefore not entitled to benefits but whom employers will not hire because of physical ailments. He felt that the employers' policy was caused primarily by the insurance companies which would not let the employers hire these people. He mentioned that he had several patients with diabetes and light forms of heart disease who were capable and willing to perform certain work, but employers with such work refuse to hire them.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I kept an appointment with Dr. ——— on December 14, 1959. He is an ophthalmologist and surgeon. At first he told me that he had not prepared a medical report during the last year. I explained that he was selected to be interviewed because his name appeared on a medical report submitted for a disability applicant. He then remembered that he prepared a medical report for an applicant whom I interviewed 1 hour earlier. He estimated that it takes an average of 20 minutes of his time and 20 minutes of the secretary's time to complete the medical report. He said that as an ophthalmologist, he is only concerned with the visual section of the medical report. He stated that this section is brief and easy to complete.

Dr. ——— said that he feels that a current examination is necessary prior to furnishing a medical report except where the disability applicant is his patient and has been recently examined. He said that if the patient had not been examined within the last 6 months from the date that a medical report is requested he would require a current examination of the patient. Dr. ——— believes that he should be compensated for preparing the medical report for the disability applicant. He feels that the patient should be charged a nominal fee to cover secretarial and other administrative costs. He stated that some hospitals charge a fee of \$1 for such services. He believes that the patient should pay the cost of a medical examination since the

patient is the one who is being benefited. He added that if the patient cannot afford the cost of the examination, the patient should go to a clinic where a nominal fee is charged.

Dr. ——— said that he has not had any direct contact with Social Security representatives. He stated that he had a very good relationship with the State vocational rehabilitation agency. He said that he had little knowledge of the requirements of the disability program. However, he does not feel that he needs any information as to the kind of medical information that is to be furnished in connection with social security disability claims. He stated that he completes the medical report form based on his examination and from the medical history of the patient.

At the doctor's request, I read to him the statutory requirements for blindness. He stated that the requirements were too rigid and covered only the extreme cases. He said that people who could meet the requirements were in serious condition and needed help. He stated that the requirement which provided that the disability applicant's visual field be reduced to 5° or less concentric contraction in the better eye with the use of a correcting lens should be changed to provide for a visual field of 10° or less. He stated that the change in the statutory requirements would make it conform to the requirements of many industrial pension plans.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— on December 28, 1959. He had not received any requests during the last month to complete a medical report for a disability applicant. It takes the doctor about 30 minutes to complete the medical report form. Doctor ——— stated that the medical report form used by Social Security was too long and took too much time to complete. He felt that the form should be brief and have fewer questions.

Dr. ——— felt that if the applicant is his patient and was under his constant care, a current examination would be unnecessary before he completed the medical report form. However, if the patient has not had an examination within the previous 6 months, a current examination would be necessary before he completed the medical report form. He felt that he should be compensated by the Government for filling out the medical report. Dr. ——— believes that the Government should also pay for a current medical examination unless the patient receives treatment as a result of this examination.

Dr. ——— did not criticize the Social Security or the State vocational rehabilitation employees. He did not feel that he had been furnished adequate information as to the kind of medical information that he should furnish to support a patient's claim to social security disability benefits. The only knowledge he has of the program is from the medical report form itself. It is his opinion that Social Security should send doctors literature about the disability program. The doctor did not comment further on the social security disability program.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— in his office on December 29, 1959. He stated that he did not furnish any medical reports for social security disability applicants last month. He said that he received approximately six such requests during the calendar year. He estimated that approximately 30 minutes of his time and 30 minutes of his secretary's time is required to complete the medical report. He explained that this estimate includes the time required to look up medical history and examine hospital reports. He stated that he had no criticism of the medical report.

Dr. ——— said that he feels that a current examination is necessary prior to furnishing a medical report except where the disability applicant is his patient and has been examined by him within the last 6 months. He stated that the patient should be charged a fee of \$3 (price of office call) for the preparation of the medical form and that the patient should pay the cost of a current examination.

Dr. ——— did not have any criticism of either the Social Security representatives or the State vocational rehabilitation employees. He mentioned that he had several referral cases from the State agency in the past year. He said that he did not need additional information as to the kind of medical information that is to be furnished in connection with social security disability claims. He stated that he had found that the doctor's findings were not sufficient for social security. He felt that more consideration should be given to the family physician's findings.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— agreed to see me on December 11, 1959 shortly after my arrival. He asked that if possible I confine my interview to 15 minutes since he had several patients to see.

Dr. ——— recalled completing between three and five social security medical report forms during the past month. In fact, some months he stated he had as many as 15 reports to prepare. The doctor emphasized that he would not sign such a report without first rendering a current medical examination. Under these circumstances the completion of the medical report could take between 15 to 50 minutes depending on the nature of the impairment to be evaluated. He feels justified in expecting payment for his time but believes that the Government should make the payment. Most of the people he has examined in connection with social security were unable to pay the fees and he has therefore given his time without charge. He feels the doctor should not be forced to take the brunt of this situation. Dr. ——— informed me he does substantial charity work through the regular course of his practice.

The doctor has no criticism against the medical report form; he finds it a rather good one. A notation to the examining doctor to fill out only the pertinent parts may be helpful, he added.

Dr. ——— sharply criticized some of the Social Security representatives he had contact with in the past. His chief complaint was that it was next to impossible to get straightforward answers to what he

believed were rather simple questions. He stated on many occasions when he called them he talked to three and four persons before he got anything close to what he wanted. Dr. ——— told me he once called the district office to find out how the "\$1200 retirement test" would affect a person retiring in the middle of the year. He stated he talked to four different persons and still didn't obtain a clear explanation. He was transferred from one person to another and when he discovered the fourth person he spoke to was the same one he talked to first, he became a "little discouraged."

Dr. ——— has no real criticism of the overall disability program. He believes it a wonderful thing and realizes, as with any new undertaking of this magnitude, many "kinks" are present which can only be ironed out in time. He does believe there is room for immediate improvement at the district office level. Either having the employees better informed or having someone capable of directing inquiries to the proper persons would help. It would undoubtedly avoid the unnecessary shuttling from one person to another when making an inquiry.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed on December 17, 1959, at his office. During the interview Dr. ——— was most accommodative and cooperative.

Dr. ——— said he had no requests during November 1959 to furnish medical reports for social security disability applicants. He averages only one or two a year. He said the average length of time required to prepare a medical report for a social security disability applicant is about 15 or 20 minutes for both himself and his secretary.

Dr. ——— said he believed the medical report required in connection with a social security disability claim should be simplified to include only the diagnosis of the case and the reason the patient cannot work.

Dr. ——— felt that the patient should be given a current examination before providing a medical report if there is a change in the patient's condition or if he has not seen the patient in over 1 year.

Dr. ——— said he did not believe he should be compensated for filling out a medical report form for his patients; however, the patient should pay for a current examination if it is necessary.

He said he had very little contact with either the Social Security representatives or the State vocational rehabilitation employees. He had no criticism to make with respect to his dealings with them. He said he felt he had been furnished adequate information as to what kind of medical information he was to furnish in connection with social security disability claims.

The only other comments Dr. ——— had on the social security disability program were that he believes some type of Government medical insurance is necessary for aged patients. He believes this should be on a 50-50 basis approach to financing.

The Forand bill, he said, with the Government paying all the expenses is open to grave abuse.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I kept an appointment with Dr. ——— on December 28, 1959. Dr. ——— is a staff physician at a tuberculosis sanitarium. The doctor stated that about five medical reports for social security disability applicants are prepared by him each month. It takes the doctor and a clerk about 30 minutes to complete the report. He believes that the medical report form furnished by Social Security is good. He indicated that he likes it better than the reports required by some insurance firms as it is shorter and requires less information.

Patients at the institution are examined once a month and therefore it is unnecessary to give a special examination in order to complete the medical report. Dr. ——— stated that the services and care provided by the institution are free to the public and therefore neither the patient nor the Government should be required to compensate the institution for filling out the medical report form.

Dr. ——— had one criticism about his dealings with Social Security personnel. He stated that over a year ago there were several instances in which he had received second requests for medical reports that had already been furnished by him. These were not requests for additional information but apparently resulted from reports being lost.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— on December 29, 1959, in his office. He spent part of his internship at a hospital where he had experience with the filing of social security disability claims.

He currently averages about one application monthly. He says all medical reports take in excess of 20 minutes and a few more than 1 hour. His opinion on current examinations is that if the applicant has not had a complete physical in the 6 months period prior to the preparation of the medical report by all means this should be a requirement. He believes the doctor should be compensated for his time and that of his secretary if the applicant is financially able to pay. As to who should pay for a current medical examination, the answer is the same, the patient if able, but he handles many cases on a charity basis.

His comment was that Social Security medical reports are sent to the physicians without any instructions or explanation as to requirements for disability. He has had no direct dealings with either the State vocational rehabilitation employees or any Social Security representative.

He does not feel that he has been furnished adequate information as to the nature of medical information he is asked to furnish in connection with disability claims. He believes that physicians should be supplied with adequate information to properly complete the medical report.

His additional comments follow:

1. He believes the Social Security disability program to be basically sound.

2. He believes there should be a way whereby individuals able to work part time could do so without working to their detriment.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I kept an appointment with Dr. ——— on December 23, 1959. He received two requests last month to furnish medical reports to support claims for disability benefits. It takes the doctor about 30 minutes to complete the medical report if no examination is given. If an examination is necessary it will take the doctor an hour or more to complete the medical report. The time expended will depend on the type and extent of examination given. He made only one criticism of the medical report form which is now in use. He felt that the form did not allow enough space for a full explanation of the applicant's condition. He suggested that a page be added to the form to be used only for additional comments.

The doctor felt that a current examination would be necessary before he could complete a medical report form for a disability benefit applicant unless he has examined the patient within the past 6 months. He believed that he should be compensated by the Government for both the examination and the medical report he prepares. However, if the patient is examined and receives medical treatment in addition to the medical report, the doctor feels that the patient should make the payment.

Dr. ——— did not criticize the Social Security or the State vocational rehabilitation employees. He did not feel that he had been furnished adequate information as to the evidence he should submit to support a disability claim. He does not recall receiving any information about the program except that on the medical report form itself. He suggested that doctors be placed on a mailing list and sent any medical information which bears on their proper performance under the program. He also felt that doctors should be informed about the disability program and that any current changes in the law should be mailed to them. Dr. ——— mentioned that he would like to know if his patients are accepted or denied. He felt that if a patient was denied he should be informed as to the reason so that he can explain this reason to his patient. The doctor also suggested that the social security program set up an employment agency to help denied applicants find employment.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I kept an appointment with Dr. ——— on December 7, 1959. He received three requests last month to furnish medical reports for social security disability applicants. It takes the doctor about 20 minutes to complete the medical report. He likes the medical report furnished by Social Security stating that it is brief and to the point.

The doctor feels that a current examination is necessary prior to furnishing a medical report, except where the disability applicant is his patient and has been recently examined. He does not feel that he

should be compensated for filling out a medical report form for his patients. Dr. ——— believes that the Government, under certain conditions, should pay for the costs of the medical examination. He stated that the Government should pay the reasonable costs for a medical examination only if the doctor finds that the disability applicant has a severe impairment. If the applicant does not have a severe impairment, the Government should not be charged for the examination. The doctor believes that a person with a severe impairment generally is not able to pay for a physical examination.

Dr. ——— did not have any criticism of either the Social Security representatives or the State vocational rehabilitation employees. He does not feel that he needs any information as to the kind of medical information that is to be furnished in connection with social security disability claims. Dr. ——— stated that he just completed the medical report and lets Social Security use its judgment in allowing or disallowing the claim.

The doctor did question the quality of the Social Security determinations as to who should get benefits. He stated that, "Too many are getting it who do not deserve it, and many are not getting it who do deserve it."

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed on December 22, 1959 at his office.

Dr. ——— said he received during the month of November 1959 two or three requests to furnish medical reports for social security disability applicants. He said the requests averaged about two a month. He said the time required by him to prepare a medical report for a social security disability applicant had averaged 20 or 30 minutes. He said he had no criticism of the medical reports required in connection with social security disability claims.

Dr. ——— said he would give all patients, as it seemed necessary, a current examination before providing a medical report. He also said he would give a patient an examination if he was not current; that is, if he had not seen him within 30 to 60 days.

He said he believes he should be compensated for filling out a medical report for his patients. He said the patient should pay for the medical report. He said if a current examination is given the patient should pay for it.

Dr. ——— said he has not had contact with Social Security representatives but has had dealings with State vocational rehabilitation employees. He had no criticism of his dealings with them.

He said he has been furnished adequate information as to what kind of medical information he was to furnish in connection with social security disability claims.

The only other comment Dr. ——— had on the social security disability program was that he does not agree with the Forand bill which requires the Government to pay medical costs. He does not believe in dependency on the Government.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I met with Dr. ——— on January 4, 1960. The doctor receives very few requests for medical reports from social security disability applicants and he could recall having received only one such request in the past year relating to his own private practice. However, in his work at the hospital he prepares about one medical report a month for disability applicants. It takes Dr. ——— about 10 minutes to complete this report if a physical examination is unnecessary and about 45 minutes if a physical examination is necessary. The doctor states that the medical report form furnished by Social Security is one of the best forms that he has seen, however, he does have one criticism of the form. Question 2(b) of the form asks the doctor the date that the applicant became unable to work. Although Dr. ——— realized the importance of this fact to Social Security, he states that a doctor is usually not aware of this date.

The doctor believes that where a patient has only been treated for minor symptoms in the past or has not had a thorough physical examination within 3 to 6 months of the request for a medical report a physical examination is necessary. He stated that, although there are times when he felt that he should be compensated for completing a medical report he does not usually charge for its preparation. Except for indigent cases, Dr. ——— believes that the patient should bear the cost of the physical examination because it is the patient who is seeking to benefit from the report.

Dr. ——— has had many dealings with representatives of Social Security and the State vocational rehabilitation agency and commented that he has "only praise" for them. He believes that he has been furnished adequate information as to the kind of medical information desired in connection with social security disability claims.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

On December 28, 1959, I interviewed Dr. ——— at his office. He is associated with several other doctors in operation of a clinic.

He had three inquiries about the social security disability program this month but had not furnished any medical reports or made any physical examinations for applicants. He stated the length of time for filling out reports varies with the type of case and takes from 15 minutes to 2 hours.

He believes that all applicants should have a complete physical when the patient has not been examined recently and that the patient should pay for both filling out the report and the physical examination. In charity cases the cost should be assumed by the doctor.

The doctor does not believe any civilian or mixed group should decide the allowance or denial of a claim but that a panel of five medical doctors should sit as a review panel and make the decisions from the medical reports.

He had no criticism of either the Social Security representatives or the State vocational rehabilitation employees and feels he was furnished adequate information as to what kind of medical information he is to furnish to complete the social security medical report.

He had no other comments except to say he was glad to cooperate and hoped his answers would help the committee.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I kept an appointment with Dr. ——— on January 6, 1960. He said that he had not received any requests last month and only one request in the past year to furnish medical reports for social security disability applicants. The doctor stated that it takes him an average of 30 minutes to prepare a report. He said that this time is necessary because a certain amount of examination work must be done in every case.

Dr. ——— stated his belief that he should be compensated for making out medical forms for his own patients and that the patient should pay because he gets the benefit. He said, however, that when the Government requests the examination the Government should pay.

I showed the doctor a copy of the medical report and asked him if he had any criticism of the form. He said that there should be a category for "gastro-intestinal disorders." He said that, in his opinion, this category should be shown on the reverse side of the form as an addition to the five categories already there.

The doctor said that he had no criticism regarding his dealings with Social Security representatives or the State vocational rehabilitation employees. He repeated that he has had very little experience with them. Dr. ——— said that he believes the information furnished him by Social Security is adequate as to what kind of medical information he is to furnish. He said that the terminology used in the medical report is very good. He had no other comments to make about the disability program.

Dr. ——— mentioned that he furnished medical evidence to an applicant I had interviewed. I told the doctor that this applicant had been denied benefits. The doctor said that, in his opinion, Mr. ——— should not do any regular work because of his heart condition.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I kept an appointment with Dr. ——— on December 28, 1959. He had not received any requests last month to furnish a medical report to support a disability claim. It takes the doctor about 30 minutes to prepare a medical report. He did not criticize the medical report form.

Dr. ——— felt that a current examination should be given to all patients before the medical report is prepared. He also believed that he should be compensated by the Government for the examination and for filling out the medical report.

Dr. ——— did not criticize the Social Security or the State vocational rehabilitation employees. The doctor said he had not been furnished adequate medical information to permit the proper completion of medical reports to support a disability claim. He stated that the only knowledge he had of the program was from the medical report form itself. The doctor stated that he would like to know more

about the disability program. He believed that Social Security should send doctors booklets, pamphlets, or any other available information. The doctor did not comment further on the social security disability program.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed on December 14, 1959, at his office. Dr. ——— was very obliging and asked a patient to wait while he took time for the interview.

Dr. ——— said that in November 1959 he received two requests to furnish medical reports for social security disability applicants and that this was about the monthly average. He said the average length of time required to prepare a medical report for a social security applicant was about 20 to 25 minutes for himself and about 10 to 15 minutes for his secretary. Dr. ——— said that the medical report form required in connection with a social security claim seemed adequate for the information desired.

Dr. ——— said he would give a patient a current examination before providing a medical report only if he had not seen the patient lately or if the condition of the patient had changed.

Dr. ——— said, emphatically, that he should be compensated for filling out a medical report form for his patients, and that both the patient and the Government should pay part of the cost because the patient gains something (disability benefits) from the report and the Government obtains a report to guide its action on a claim. He said he believes that he should be reimbursed for a current medical examination on the same basis.

Dr. ——— said he had established excellent relations with Social Security representatives and State vocational rehabilitation employees and had no criticisms of his dealings with either group.

He said that he has been furnished adequate information as to what kind of medical information he is to furnish in connection with social security disability claims. He said specific questions are listed on the medical report form and specific answers are given.

He had no other comments on the social security disability program. I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was able to give me some time near the end of his visiting hours on December 14, 1959. The doctor maintains an extremely heavy schedule; however, he was very eager to cooperate in any way he could.

Two or three medical reports were all Dr. ——— could remember preparing during the past month. He has found it necessary to fill out more on occasions, but estimates he averages one or two a month. The doctor feels, to properly fill out the report, more than 1 hour would be involved and he has required two visits on many occasions before completing the form. One visit by the patient, he confines to securing historical data, weight measurements, etc. The doctor requires his patient to bring in any specimens when needed and gives him additional tests and X-rays on the second visit. Dr. ——— believes the

actual filling out of the medical report and the examination cannot be segregated and, therefore, compensation is definitely in order under these circumstances. Since disabled persons under the disability program are normally without funds, he believes the Government should reimburse the doctor for his time.

Dr. ——— thinks the medical report form is a good one and serves as a guide to the type of medical information wanted by Social Security. He believes it helpful and almost a necessity in some cases to elaborate on certain findings entered on the report. He finds this can best be done by attaching a narrative statement to the medical report form.

The only criticism Dr. ——— offered against the disability program, in general, was the tremendous amount of time involved in processing cases. Patients come to him destitute, often having waited months for their checks. He stated he has known some applicants who spent their entire life's savings, borrowed until they are unable to borrow any more, and finally gone on public relief waiting for benefits. It certainly isn't a healthy situation for these persons, in addition to being disabled, to be subjected to this mental anguish, he added.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I telephoned Dr. ——— December 22, 1959, and made an appointment with him for that afternoon. The doctor receives very few requests for medical reports for disability applicants. He could recall only one such request in the last 6 months. It takes the doctor from 15 to 20 minutes to complete the medical report form which does not include the time required for a physical examination if one is considered necessary. He believes the medical report form is brief and complete for the purpose intended.

Dr. ——— stated that the determination as to whether a physical examination is necessary in furnishing a medical report would depend on the circumstances. If the applicant was currently under his care for the disability, he believes that generally an examination would not be necessary. The doctor does not charge his patients for filling out a medical report but believes it only fair to have a fee for an examination. He stated that the fee for the medical examination should be borne by the Government in those instances where the applicant is in poor financial circumstances.

The doctor had no criticism of his dealings with representatives of Social Security and the State vocational rehabilitation agency.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— at his office on January 6, 1960, and found him most cooperative.

He estimates that he has completed about five medical reports for disability applicants last year. He says the average time for preparation of a medical report is from 20 minutes to an hour. He thinks a complete physical should be given all applicants if they have not had one within the prior 30 days. He believes the patient should pay for the medical report and examination. His only criticism of the medical report form is that the space is limited and necessitates at times the preparation of a narrative supplement.

He has no criticism of his dealings with either the Social Security representatives or the State vocational rehabilitation employees. He felt he had been furnished adequate information as to the kind of medical information he is to furnish in connection with social security disability claims.

The doctor said:

It is rather a difficult thing to say or describe but I feel that when a doctor is asked to fill out a form for his own patient to enable them to get favorable action on a disability claim, it is almost impossible for a doctor to be unbiased in his statements and examination.

He said he felt this so strongly that he would like to suggest that all applicants be required to undergo a complete physical examination by a doctor who has not had him as a patient—in addition to a file record from his family or personal physician. He said this would be less of a burden on the individual's personal physician and more equitable to both the individual and the Government. He stated he had discussed this situation with other doctors and they are in agreement.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I kept an appointment with Dr. ——— on December 18, 1959. He estimated that he furnishes about one medical report a month for social security disability applicants. It takes the doctor less than 20 minutes to prepare a report; however, if an examination is required it takes an additional one-half hour. Dr. ——— said he will give the applicant an examination unless he has examined him recently.

The doctor believes that he should be compensated for his time and expense in preparing any medical report. He said that, in his opinion, the Government should pay for the medical reports and for any current examinations. He said the medical report form could well be longer in the section (reverse side) requesting specialist's findings. He said that in his specialty (orthopedics), bone diseases can have numerous different causes and, for this reason, space for a specialist's opinion should be provided on the form.

The doctor did not have any criticism of his dealings with Social Security representatives or the State vocational rehabilitation employees.

Dr. ——— believes that many people who receive benefits at age 50 and thereafter stop all useful work are putting themselves at a great disadvantage. He said that more effort should be made by applicants to find work in which they could engage with physical and mental benefit to themselves.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed on December 17, 1959, at his office. Two applicants were examined by him last month. He said it takes him about 20 minutes to prepare a report for a Social Security disability applicant.

A patient is generally given a current examination before the doctor provides a medical report. Dr. ——— said he feels he should be

compensated for filling out a medical report for his patients and that the Government should pay for it. If a current examination is given, the patient should pay for it.

Dr. ——— had no criticism of the medical reports required in connection with the social security claims or of either the Social Security representatives or the State vocational rehabilitation employees. He said he feels that he has been furnished with adequate information as to what kind of medical information he is to furnish in connection with social security disability claims.

Dr. ——— had no comments on the social security disability program.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— on December 14, 1959. The doctor was tired after a long and busy day, but he seemed eager to cooperate.

Neither Dr. ——— nor his nurse could recall filling out any social security medical reports during the past month. In fact, he told me he perhaps completed only one or two over the past 2 years. After reviewing the medical report form briefly he estimated it would take 20 minutes to prepare if the applicant were a regular patient. Otherwise he asserted it would take much longer to complete. Dr. ——— stated he would make a current examination in all cases before completing the form unless the patient were visiting him regularly. He believes reimbursement for his time and services are warranted, especially so, when an examination must be made. Dr. ——— emphasized strongly his belief, that the Government should bear this expense; first, because they were seeking the information and secondly because the applicants probably couldn't afford to pay the fee anyway.

Dr. ——— believes the form is good generally, but he thought a more detailed description of some impairments might be necessary. The doctor couldn't remember ever having any unpleasant dealings with representatives of either Social Security or the State vocational rehabilitation agencies.

When asked if he had any overall comments on the disability program, Dr. ——— stated he thought perhaps Social Security representatives gave applicants the impression it was easy to qualify for benefits. Through discussions with his colleagues, he learned some of their patients file applications for social security benefits with less than 50 percent disabilities and then are greatly surprised when turned down. They then become indignant and either blame their doctor for not properly filling out the medical report or get the impression that the disability program is so strict you must be at "death's door" to qualify.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed on December 11 1959 at his office. Dr. ——— said he received only one request during November to furnish

a medical report for a social security disability applicant and that this was about average. He, alone, prepared the medical reports, Dr. ——— said he believed some parts of the medical report form are repetitive and he referred to item 3 on the front of the form and to "Respiratory" on the reverse of the form.

Dr. ——— said he believed he would give a patient a current examination before providing a medical report only if the patient's general condition may have changed. Dr. ——— said he should be compensated for filling out a medical report for a patient and the patient should pay. Also, if a current medical examination is given, the patient should pay. However, he does not believe he should charge indigent patients.

Dr. ——— said that he had not had contact with either Social Security representatives or State vocational rehabilitation employees. Dr. ——— said he believed he had been furnished adequate information as to the kind of medical information he was required to furnish in connection with social security disability claims.

He said it would be helpful if he knew the ultimate disposition of the patient's application. He feels doctors should know more about the functioning of the social security disability program because it would be helpful to both doctor and patient.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I met with Dr. ——— on December 29, 1959. The doctor, a surgeon, stated that he has not processed any requests to furnish medical reports for social security disability applicants during the last month and that he could recall preparing only three since January 1, 1959. The doctor feels that a patient should always be given a current medical examination at the time the medical report is prepared. He stated that the examination and preparation of the report takes about an hour.

The doctor criticized the medical report required in connection with social security claims; he said that the report must have been prepared by a layman. The doctor questioned how any determination could be made from the report which he believes is not sufficiently complete to disclose all types of conditions and at best is nothing more than "sketchy." He stated that he would like to see a standard medical report form for all Government agencies similar to the one used by the Department of the Army. He believes that the Department of the Army form is sufficiently complete to show the extent of the examination made and the resultant disclosures; in addition, he feels the format of the report, which provides boxes for the doctor to check off, simplifies preparation of the report. The doctor feels that standardization of medical report forms by the Government would promote familiarity with one report form, and eliminate unproductive time now required to familiarize oneself with many different types of medical report forms.

The doctor feels he should be compensated by the Government for filling out the medical report and making the examination because both the report and the examination are required by the Government. He likened the Government's request for the medical report and the

medical examination to a request from an employer hiring a new employee and stated that the employer usually compensates the doctor because the employer requested it.

The doctor cannot recall any dealings with either the Social Security representatives or State vocational rehabilitation employees. In commenting on the social security disability program, the doctor said he was very much against the proposed Forand bill because he believes this will lead to socialized medicine. The doctor stated he disliked the way medicine was practiced in the Army and that socialized medicine would lead to similar practices which destroy individual incentive. The doctor believes that any form of Federal medical aid is unnecessary. He stated he has never heard of a case where a destitute person could not receive treatment at some local clinic or county hospital.

The doctor questioned the State determinations made under the disability program; he said that the people who make the determinations occupy purely administrative positions and are not to be considered professional medical people because they are employees of the State rather than practicing physicians. He stated that some of his patients suffering from arteriosclerosis and considered disabled by all the doctors in the medical center building were nevertheless denied disability benefits because of the State agency determination.

In addition, the doctor stated he is opposed to Federal intervention in many things because he feels the Government is composed of "mostly bureaucrats who are on coffee break when you want something."

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed the doctor for 15 minutes on January 6, 1960, in his office attached to his home in a town of about 500 population. His office was full of patients. He had not received any requests during the last month to furnish medical reports for social security disability applicants but estimated he averaged three per year. He stated it took him about 1 hour to prepare the report. He had no criticism of the report.

Dr. ——— felt that he should always give the patient a current examination before providing a medical report.

The doctor makes no charge and did not feel he should be compensated for filling out the medical report form for his patients. However, he does charge for a current medical examination for the report and felt the Government should pay for this because most patients needing it cannot afford it.

Dr. ——— had no criticism of his dealings with either the Social Security representatives or the State vocational rehabilitation employees. He felt he had been furnished adequate information as to what kind of medical information he was to furnish in connection with social security disability claims. The doctor did not understand, however, why more disabled people such as Mr. ——— who was the subject of a separate interview did not get social security disability benefits. He felt more people aren't getting them who should be than people getting them who shouldn't.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— on December 30, 1959. He received one request during the last month to complete a medical report form for a disability applicant. It took the doctor less than 20 minutes to complete the medical report. He did not criticize the medical report form.

Dr. ——— felt that a current examination should be given all patients before a medical report is prepared. The doctor believed that he should be compensated for the examination and for filling out the medical report form. He stated that the patients should make the payments since they are applying for the benefits.

Dr. ——— did not criticize Social Security or the State vocational rehabilitation employees. He felt that he had been furnished adequate information as to the kind of medical information which he needed to properly complete a medical report. The doctor did not comment further on the social security disability program.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— in his office on December 31, 1959. He advised me that he has been against Social Security since its inception and he did not think it was good for the country. He explained that social security, including the disability program, destroys the initiative to work on the part of many people who normally would be willing and able to continue working. He said that, in his opinion, a number of people who are capable of working are applying for disability pension. He said that he neither advises his patients to apply for disability nor represents them at hearings. I found Dr. ——— to be sincere and courteous.

He stated that he had received one request to furnish a medical report for a social security disability applicant last month. He estimated that he had received four or five such requests during the calendar year. He said that it takes him about 20 minutes to complete the medical report. He had no criticisms of the medical report.

Dr. ——— emphasized that he would require a current examination prior to furnishing a medical report except where the applicant is his patient and has been examined by him within the last 6 months. He stated that the patients sometimes expect the doctor to fill out the form without an examination. He said that last month a woman left a medical form with his secretary for him to complete. He said that in his opinion the woman was not entitled to disability benefits and therefore he refused to complete the form until he could perform an examination. He said that as of the date of this interview the woman had not contacted him and he had not prepared the form. He stated that, depending on the circumstances of the patient, he believes that he should be compensated for filling out the medical report. He believes that the fee should be equivalent to the price of an office call. He pointed out that he is against the Government paying for services that benefit an individual. He said the patient should pay for the preparation of the report and for the examination.

He did not have any criticisms of Social Security representatives but he stated that the State vocational rehabilitation people "muddle" into the private affairs of the people. He believes that all social agencies have a tendency to grow beyond the purpose for which they were created. He said that he did not need additional information as to the kind of medical information to be furnished in connection with social security disability claims.

He said that some people are getting disability benefits but are not entitled to them. He did not care to elaborate on this statement. I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I kept an appointment with Dr. ——— on December 15, 1959. Dr. ——— stated that he has had considerable experience dealing with persons in the lower income brackets, many who spent years on public relief, and he has a profound feeling for their many problems and shortcomings. The doctor thought that only these persons, in the lower income brackets or those forced to accept public relief, can avail themselves of the disability program's benefits.

Dr. ——— prepares on the average of one social security medical report a month. He remembers completing one several weeks ago. To complete one of the medical reports, the doctor estimates 15 minutes would be required providing the applicant is a current patient. Dr. ——— believes a current examination is important in all cases before completing the report unless he has recently examined the patient. He feels justified in seeking remuneration for the preparation of the report since usually an examination is required along with it. He expressed his views strongly that the applicant should bear the cost of filling out the report. He believes this might discourage some, who know they cannot qualify but file regardless, feeling they have little to lose. Dr. ——— stated he would not turn a patient away if he were unable to pay but even under these circumstances, he cannot find justification for the Government paying the cost.

Dr. ——— commented that the report form did not clearly indicate the full extent of the information Social Security desired. He backed his statement up by stating that Social Security had written him on several different occasions seeking additional information after he had completed a medical report.

Dr. ——— recalled no unpleasant dealings with representatives of Social Security nor with the State vocational rehabilitation agency. Whenever he needed to contact them he found them most courteous.

The doctor believes the disability program is a great humane effort, something we can justly be proud of. He would like to see some of the rigid standards relaxed but realizes this can only be accomplished through a gradual process.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed on December 16, 1959, at his office. Although he answered each question quickly his answers seemed to be well thought out.

Dr. ——— said he had not filled out any medical reports for social security disability applicants during the past month; he had filled out only two in his entire period of practice. He estimated it would take about 45 minutes to prepare the required medical report—30 minutes of his time and 15 minutes of his secretary's time. He had no criticism to make about the medical reports required and said he found them to be suitable for their purpose. He had no trouble with them.

Dr. ——— said he believed a current medical examination would be necessary only if he were seeing someone new or if the patient had not been examined recently.

Dr. ——— said he definitely believed that he should be compensated for filling out the medical report and, also, that he believed the Government should pay for it because the patient is already financially pressed. If a current examination is given he believes the patient should pay for it because it will be for the direct benefit of the patient.

Dr. ——— said he has not had any contact with Social Security representatives or State vocational employees. Other than the medical report form he had not received any information as to what kind of medical information he should provide. He said he did not have any trouble with the forms he filled out, explaining that they were "clear cut." He had no suggestions.

As a whole, he said, he was much impressed with the operation of the program. He said the Social Security district office accepted his reports and did not bother him for more information. He thinks the program is a "good thing."

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I met with Dr. ——— on December 24, 1959, after making an appointment with him by telephone. The doctor stated that he had not received any requests to furnish medical reports for social security disability applicants during the last month. He stated that he recalls receiving only two since January 1, 1959. The doctor personally fills out the medical report and spends about 45 minutes in making the examination and preparing the report. The doctor stated that the medical report required for social security disability applicants covers too much area in too great detail. He believes that the report should only cover the applicant's particular ailments.

The doctor feels that a current examination should always be made before providing a medical report to any government agency or any other source. The doctor showed me his schedule for the afternoon of December 24 on which he had appointments with patients almost every 15 minutes. Because processing the report takes about 45 minutes, the equivalent time of seeing three patients, the doctor feels he should be compensated for providing a medical report. He further stated that the Government should pay for the report because they require it and often the cost of the report works a hardship on the disability applicant. In regard to the medical examination, the doctor believes that the patient should bear the cost of the examination since it is beneficial to the patient in disclosing current maladies.

The doctor had no criticism as to his dealings with representatives of Social Security or the State vocational rehabilitation agencies. The doctor, commenting on the social security disability program, stated that he feels the Administration fails to look beyond the nature of the disability in determining whether a person is totally and permanently disabled from all types of gainful employment. In elaborating on this, the doctor cited his own condition as an example case. He stated he recently has returned to work after suffering a coronary attack. He feels that his own familiarity with his condition, his ability to perform an administrative function and his determination to return to work were factors which precluded him from being totally and permanently disabled. He stated that a person with less understanding of coronary symptoms, with a fear of further recurrences and with a capacity for only physical labor could truthfully be totally and permanently disabled from all gainful employment.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

On December 14, 1959, I interviewed Dr. ——— at his office. Dr. ——— prepares about six medical reports a month for disability applicants. It takes him about 30 minutes to prepare the report. He has no criticism of the medical reports required in connection with social security claims.

Dr. ——— thought an examination was essential before preparing the report if the applicant was not a current patient. He thought the applicant should pay him for preparing the medical report and if a current medical examination is given, the applicant should also pay for that.

In general comments about the disability program, the doctor stated that the practice of requiring a medical report from more than one doctor was an undue burden on the applicant. Dr. ——— also stated that the disability program should be better explained to the applicants. He stated that in many instances the applicants do not understand when they are eligible for benefits and blame the doctor when benefits are not allowed.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed on December 16, 1959, at his office.

Dr. ——— thought he had two requests during November 1959 to furnish medical reports for social security disability applicants. He said that, in fact, they were the only two requests he received during the year 1959. He said it had taken him about 5 or 10 minutes to prepare a medical report for a social security disability applicant. He had no criticism of medical reports required in connection with social security disability claims. He believed the report form is sufficiently satisfactory.

Dr. ——— said if there was a change in the patient's condition or if he suspected there was a change he would require a current examination of the patient before providing a medical report. Dr. ——— said he believes he should be compensated for filling out a medical

report form for the patient. He said, as a rule the patient should pay for the preparation of the medical report but, on the other hand, he feels the Government should pay if the patient is incapacitated and cannot work. He said that he believes the patient should pay for a current examination when it is required for a medical report but if the patient cannot work the Government should pay.

Dr. ——— said he has not had contact with Social Security representatives or State vocational rehabilitation employees. He feels he has been furnished adequate information as to what kind of medical information he was to furnish in connection with social security disability claims. He thinks the medical report is sufficiently clear.

The only other comment Dr. ——— had on the social security disability program was to say that it should be made clear to the patients that they should pay for services required, if they have the ability to do so.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I met Dr. ——— in his office on December 18, 1959.

The doctor stated that he has not processed any medical reports for social security disability applicants recently. But he estimated that he processed five or six since January 1959. Dr. ——— stated that he personally fills out the medical report and that it takes him about an hour. The doctor is a former Army lieutenant colonel. He stated that the medical report required for social security disability applicants is very sensible compared to those required by the Army, private insurance companies, and other Government agencies. He stated a great amount of thought must have gone into its preparation.

The doctor feels that a current medical examination is necessary when furnishing a medical report, except in those cases where the disability applicant has been his patient for some time and has been examined within the last 30 days. He feels he should be compensated for filling out a medical report since it takes him about an hour to prepare it. The doctor believes that the patient should pay for the medical report and the examination. Dr. ——— stated that since the patient requests the report and examination it is to his personal advantage to pay for it; otherwise, too many people who could not qualify would request examinations.

Dr. ——— could not recall having any dealings with Social Security representatives or State vocational rehabilitation representatives. He stated that most of his dealings are with the county welfare group. This local government organization pays for medical expenses, drugs, and so forth, for the destitute. Dr. ——— stated that he has been given adequate information as to the kind of medical information he is to furnish in connection with social security disability claims and again expressed his satisfaction with the medical report form supplied by the Social Security Administration. The doctor stated he was not familiar enough with the details of the social security disability program to make any other comments.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— on January 4, 1960, in his office. The doctor was cooperative in answering the questions and definite in his opinions.

Dr. ——— stated he does not record requests to furnish medical reports for social security disability applicants, but he averages two or three monthly. He said the time he and his secretary spend in preparing the report is about an hour. His criticism of the medical reports was that on his particular speciality, internal medicine, he does not find enough space on the form to properly state the detail. He is of the opinion that a complete narrative report would be more efficient and complete. The doctor believes the applicant should have a current examination if he has not had one in the past 6 months to a year.

Regarding compensation for filling out the medical report, the doctor said he had not charged a patient for this service as yet; but if there were a charge for either the preparation of the report or for a current examination, the patient should make payment.

He had no criticism of either the Social Security representatives or the State vocational rehabilitation employees and added he had never seen one of the former. The medical reports are handled by mail both to and from the Social Security office. He stated he had not been furnished any information by Social Security as to the kind of medical information he is to furnish on reports, other than the medical report itself. He believes that a doctor preparing a medical report for one of his patients would tend to give the patient a break. He said that an applicant would get a more proper examination if examined by a physician who had not seen him before.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I kept an appointment with Dr. ——— on December 18, 1959. He is a general practitioner with a very busy practice. Dr. ——— said that he has had one request during the last month to furnish a medical report for a disability applicant. The doctor said that it takes him about 1 hour to prepare the report for an applicant including a medical examination.

Dr. ——— believes that the Government should compensate him for filling out a medical form or for any current medical examination he gives in connection with social security medical reports. The doctor said that the medical report is a good form and gives him all the information he needs to complete it.

Dr. ——— said that he never had any difficulties with Social Security representatives or the State rehabilitation employees, and that in his opinion these people are doing a very fine job. The doctor's only comment on the disability program was that it was a great help to the people who need help the most.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed at his office on December 28, 1959. He said he had received only one request during the last month for a medical report from a social security disability applicant. It takes him about 20 minutes to prepare a medical report.

Dr. ——— said that it is customary for him to give the patient an examination when he has not seen the patient within 6 months. He believes he should be compensated for filling out a medical report and that the patient should pay for it. If a current medical examination is required, he feels that the patient should also pay for it. He said he had no criticism to make of the medical report forms required in connection with social security claims, the Social Security representatives or the State vocational rehabilitation employees. Dr. ——— said he feels he has adequate information as to the kind of medical information he should supply on the medical report forms.

He felt there should be some way that a doctor can indicate to the Social Security office (on the medical report) when a patient has pressured him to assist in getting benefits not deserved without disclosing this information to the patient.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

On December 15, 1959, I interviewed Dr. ——— at his office. Dr. ——— had not received a request for a medical report from Social Security during the last month. It takes him less than 20 minutes to prepare the report and he feels that an examination should be given the applicant just before he prepares the report unless the applicant is under current care.

Dr. ——— believes that he should be compensated for preparing the report. He thinks the applicant should pay for the report and the current medical examination. He has no criticism of the medical reports required in connection with social security claims.

The only kind of medical information Dr. ——— is aware that Social Security wants in connection with the disability program are the medical reports. He thinks that it takes Social Security too long to process the medical reports. In general comments about the program Dr. ——— stated that it would be helpful to the general practitioner if Social Security would designate clinics to send applicants for special examinations or tests. Cost of the clinical examinations should be paid for by the applicant.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed on December 14, 1959, at his office. Dr. ——— explained that he was a nose and throat specialist and, therefore, he receives very few of the forms to fill out for Social Security. He has not filled out any forms in the last month. He said the form is filled out by his secretary from a card that is kept for each patient. He would only approve it. Dr. ———'s only criticism about the form was that it had nothing about hearing loss; however, he said that could be written on the form by the doctor.

Dr. ——— said that he felt a current examination would be warranted only if the claimant had some additional trouble subsequent to a previous examination or if 6 months had elapsed since the last visit. Dr. ——— said he does not believe that compensation for the preparation of the medical report is necessary. He said he does not charge for filling out insurance forms and he couldn't see any difference. He did not want to make a "blanket" statement of who should pay for a current examination. He believes that an initial examination should be paid for by the patient and other examinations by the Government.

Dr. ——— said he has not had any contact with Social Security representatives or State vocational rehabilitation employees. He could not recall that he had received any information explaining what kind of information Social Security wants, other than the medical report. He did not have any suggestions. His only comment about the disability program was that he hopes it is not a step toward socialized medicine.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I met with the doctor in his office on January 4, 1960. The doctor, a surgeon, can recall furnishing a medical report for only one social security disability applicant since January 1, 1959. The doctor stated that very few patients visit his office and most of his work is referred to him by other doctors. He stated that it requires about 30 minutes for him to prepare a medical report from his records on the applicant.

The doctor said that he makes very few examinations, except those required in connection with surgery he is to perform. He refers requests for regular examinations to associates in the same building. However, he feels that a patient with a chronic complaint should always be given a current examination before a medical report is furnished in connection with a social security disability claim. The doctor stated that the medical report form appears to be a comprehensive report providing for minimum diagnosis. He feels the report adequately describes the medical information which is necessary for social security disability claims.

The doctor feels he should be compensated for filling out a medical report form for his patients. He feels that since the Government requests the medical report they should pay for it. However, regarding the current medical examination, the doctor stated that he believes the patient should pay for the examination because he has chosen the doctor and has established a private relationship between himself and the doctor.

Dr. ——— stated that he has not had any dealings with either Social Security representatives or State vocational rehabilitation employees.

The doctor, commenting on the social security disability program, stated that some consideration should be given to individuals with chronic complaints who are unable to work, yet whose impairment cannot be disclosed or isolated by various laboratory tests or clinical reports.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed the doctor by appointment at his office on January 5, 1960. He averages about three requests monthly for a medical report in connection with disability applications but does not keep a record of them as such. He stated it required about 1½ hours for him and his secretary to prepare the medical report. He was of the opinion that the medical report form could be improved by allowing more space for some answers, simplifying the questions and making them more to the point. The doctor felt a complete physical examination should be made at the same time the medical report is prepared.

He has not been charging for preparation of the medical report and believes if a charge is made for this service or for a physical examination the patient should make payment.

He commented that it requires too much time to get a decision after the medical report is filed. He felt that in some cases he does not have sufficient information as to what medical information he is to furnish on disability claims. He said no one ever talked to him about it and the forms were sent through the mail. He further stated that "some people get allowances because of knowing well somebody in the Social Security or State offices, or somewhere," but said he wouldn't want to go into specific cases.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I kept an appointment with Dr. ——— on December 28, 1959. He estimates he prepared about 10 medical reports last year for social security disability applicants. The doctor said that he takes on an average of 15 minutes to prepare a report. The doctor favors giving the patient a current medical examination prior to completing the medical report.

Dr. ——— believes that he should be compensated for filling out a report form and examining his patients. He believes the Government should pay if they request it and the patient should pay if he requests the medical report.

The doctor said that in at least two places there should be supplemental space provided on the medical report. The two places are:

1. Front page, item 3(b), "Objective findings."
2. Reverse page, item 7, "Neurological" comment.

The doctor feels that he has been furnished adequate information as to the kind of medical information he is to furnish Social Security in connection with disability claims.

The doctor commented on the present requirement that the claimant be so far disabled that he cannot pursue any type of gainful occupation. The doctor stated that in accident and health insurance if a mail carrier is prevented from carrying mail because he is disabled that is sufficient even if it is found that the man could possibly sit inside the post office and, for example, answer a telephone or count and sort stamps. Social Security, he said, should require a medical finding of permanent and total disability and deem that sufficient for payment of disability benefits. Dr. ——— stated his belief if a person

is disabled so far as not to be able to do what he has been trained and accustomed to do, any pressure to earn an income in some other occupation might seriously detract from or make worse the already impaired condition of his health. In the doctor's opinion the claimant when chronically ill and incurable should not be required to drive a car, answer a telephone or be compelled to move about in any way except as prescribed by his physician.

Dr. ——— told me that he was quite familiar with the State rehabilitation agency. He said that in his experience he had seen instances where State rehabilitation had sent out investigators to make what amounted to medical determinations in the field, and he knew for certain that these investigators had only a "pseudoknowledge" of medicine. He said that frequently these investigators are badly in error.

He described his experience with one of his own heart patients that had been denied disability benefits. The doctor said that this man had a severe heart condition and had suffered several strokes. The doctor said, "I don't believe this man will ever see 1961."

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed in his office at ——— hospital on December 30, 1959. He said he had not received any requests during the last month to furnish a medical report for a social security disability applicant, but that it requires about 20 minutes to complete the report form. Dr. ——— said he always gives the patient a current examination before providing a medical report and that he feels he should be compensated for filling out a medical report for patients. Dr. ——— said he believes that the patient should pay for the medical report and the medical examination.

Dr. ——— said he had no criticism to make of the medical report form, the Social Security representatives or the State vocational rehabilitation employees. He said that the kind of medical information required could be better stated to be more useful as a guide, but he had no other general comments on the social security disability program.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— received two requests last month to furnish medical reports for social security disability applicants. If the patient's medical records are in his active file it takes about 30 minutes to prepare the medical report. Sometimes he has to search for the information if it is not in his active file and this takes longer. The present medical report form used by Social Security is considered to be "all right" by Dr. ———.

The doctor believes that it is preferable to give the patient a current physical examination prior to preparing the medical report. The doctor noted that the patient does not generally bring in the medical report form, but either mails it or has the Social Security office mail it for him. The doctor believes that the Social Security

office should insist that the applicant bring the medical report personally to the doctor.

Dr. ——— stated that doctors should be reimbursed for costs incurred in preparing medical reports. He said that insurance companies pay from \$3 to \$7.50 for this type of information. He stated that some people are not willing to pay for this and it would be a job collecting it.

Dr. ——— hasn't heard from the State vocational rehabilitation agency in over 2 years. He believes that the State agency should do a better job explaining to doctors the coverage of the vocational rehabilitation program.

Dr. ——— believes that Social Security should furnish more information about the disability program. He wonders why some people get benefits and why some are denied. The doctor said he knows of a case where a man has been trying to get benefits for several years. This man, in the doctor's opinion, doesn't seem able to get benefits although he is not physically able to work.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed on December 15, 1959, at his office. Dr. ——— at first said that he had never filled out one of the social security medical reports. After he was shown a copy of the medical report form he said that maybe he had filled one out. He said the form was "perfectly satisfactory" and that if the information was on file it would take about 20 minutes, combined time for him and his secretary to prepare it.

Dr. ——— said he believes that a current examination would be necessary only if the information requested was not on file, or if it was not reasonably current. He defined reasonably current as being about 4 or 5 months. He said he believes that he should be compensated for the preparation of the form and that it should be paid for by the person requesting the "pension." If a current examination is necessary, he believes that should also be paid for by the patient.

Dr. ——— said he has not had any contact with Social Security representatives or State rehabilitation employees. He thought the medical report was adequate but he was not sure whether he had received any additional information or not.

When asked if he had any other comments about the social security disability program he seemed to get it confused with a welfare program. But, in general, he said that he felt the Federal Government had been introduced into an area that was traditionally a local function. He believes that taking care of the old people is a local function.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I kept an appointment with Dr. ——— on December 22, 1959. The doctor could not recall specifically how many requests he had received during the last month to furnish medical reports for social security disability applicants; however, he estimated that he receives about four each month. The doctor stated that preparation

of the report takes about 15 minutes of his secretary's time and an initial medical examination takes approximately 45 minutes of his time.

The doctor criticized the medical report form required in connection with social security claims as being too specialized for a general practitioner. He stated that he feels that some of the questions on the report would more properly be directed to a specialist rather than to general practitioners like himself. The doctor, whose office is located in a low-income section of the city, stated that many of his patients are infrequent visitors to his office because of their poor financial position. In addition, he said that when these poor people visit his office he cannot spend time and money on expensive laboratory tests, X-rays, cardiograms, and so forth, because many of his patients look upon him with disdain if he presents them with a bill. The doctor showed me an 8- by 5-inch card on which he had written dates and notes pertinent to a particular patient's three or four visits over approximately a 2-year period. The card showed that the patient had received medical treatment after complaining of various minor disorders. The doctor then showed me a second request letter from the State vocational rehabilitation agency, requesting the doctor to fill out the enclosed neurological report on the same patient. The doctor questioned why the State agency had not sent the report and the patient to a specialist rather than to him because he has had no current contact with the patient and only superficial information on file regarding the patient's condition.

The doctor feels that a current medical examination is necessary prior to furnishing a medical report unless the disability applicant has been examined by him within the last 30 days and it is apparent that the applicant's condition has not changed. The doctor feels that he should be compensated for filling out the report, and that if the Government would make reimbursement the medical report would, on a professionalwide basis, be more factual and less prejudiced. The doctor stated that he would be happier if the Government not only paid for the examination but actually hired doctors to make the examination. Many patients whom he knows have nothing wrong with them come to him to furnish a medical report for a social security disability claim and, after being denied benefits, question the adequacy of the medical report submitted by him. He stated that examinations by Government doctors would eliminate much of the administrative redtape and also weed out unqualified applicants more rapidly.

The doctor had no criticisms of his dealings with either the Social Security representatives or the State vocational rehabilitation employees; however, he again criticized the extent of the questions he is required to answer as a general practitioner.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— on December 30, 1959, in his office.

In response to questions, he stated that he did not maintain accurate records on these totals but guessed he had about six requests for medical reports in the last month. He estimated it took about 25 minutes to complete the medical report form. He believes a physical examination should be given if there is none of record in the past 6 months.

He does not believe he should be compensated for filling out the medical report and, if a physical examination is required, that the Government should pay for it. The doctor said that the applicant is usually aged and penniless, and the program should help him obtain what is due him under the law. He had no criticism of the medical reports required, nor of the Social Security representatives and the State vocational rehabilitation employees.

He states he feels he has been furnished adequate information regarding the kind of medical information he is expected to furnish in the medical report and had no other comments on the program.

I thanked the doctor for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— on December 14, 1959. He had read our letter carefully, he said, and understood the objectives of the visit. The doctor is an eye specialist and only completes the eye part of the medical report.

Dr. ——— said that he believes that he should be paid for his time. He said that, in general, the Government should pay the examination fee. He remarked that disability applicants generally cannot afford to pay. Dr. ——— had no specific criticism of the medical reports. The doctor had no comment about his dealings with either the Social Security representatives or the State vocational rehabilitation employees. He said he has found in his experience that the regular general practitioner has not sufficient equipment to make all the necessary tests, etc., required to complete the medical report form. He remarked that such forms and reports if inadequately supported could result in great unfairness to the patient and, possibly, also to the Government.

Dr. ——— said that he lives among "millionaires." He said that he knew some of these wealthy people were drawing social security benefits and he was sure they had no more need for them than he had. In his opinion, such people at the most should receive a refund of their contributions and receive no benefits at all.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed in his office on December 18, 1959. He said that he had probably received less than 10 requests during the last month to furnish medical reports for social security disability applicants and that it takes less than 20 minutes to prepare a medical report form. He said that he always gives the patient a current examination before providing a medical report and he feels that the patient should pay for the medical examination which he requires. He also believes that he should be compensated by the patient for filling out a medical report.

Dr. ——— did not criticize the medical report forms required or the employees of the Social Security and the State vocational rehabilitation offices. He said he feels that he has been furnished adequate information as to the kind of medical information he is to furnish social security applicants. He did not volunteer any general comments on the social security disability program.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— is a surgeon and seldom furnishes medical evidence for a disability applicant.

I showed Dr. ——— a copy of the social security medical report. He reviewed the form and stated that it is a good one. The doctor stated that he is glad to complete the social security medical report for worthy cases. He believes that these reports do not cause enough trouble to be worth charging for their preparation.

Since Dr. ——— is a surgeon, he does not give medical examinations for the purpose of completing medical reports. He prepares medical reports based on information available in his files.

Dr. ——— did not have any criticism of his dealings with either the Social Security representatives or the State vocational rehabilitation employees. He feels that he has sufficient information as to the kind of medical information he is to furnish in connection with social security disability claims.

Dr. ——— said, "The social security disability program puts a premium on laziness."

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed on December 16, 1959, at his office. Dr. ——— said that during November 1959 he had received two requests to furnish medical reports for social security disability applicants. He said the number of requests averages from 15 to 20 a year. He said the average time required to prepare a medical report for a social security disability applicant is from 15 to 20 minutes for himself plus about 10 minutes for his secretary.

Dr. ——— said he favors the standardization of all medical report forms except those required for industrial accident cases. He also favors submission of a narrative letter as a substitute for a medical report form. Many insurance firms, he said, request a narrative letter.

Dr. ——— said that if the patient is not current, that is, had not been examined within the last 90 days, he would call for an examination of the patient before providing a medical report. Dr. ——— said he should be compensated for filling out a medical report for a patient. He said it is a moot question as to who should pay for the medical report, the patient or the Government. Logically, it should be the patient who pays, but, for the most part, the patient is medically indigent and unable to pay. (Medically indigent as he described it: Able to pay for groceries and subsistence items but unable to pay doctor bills.) He said the patient should pay for a current medical examination if it is required, but, again, it is a moot question.

Dr. ——— said that Social Security representatives and State vocational rehabilitation employees were cooperative in his dealings with them. He said he has been furnished adequate information as to what kind of medical information he is to furnish in connection with social security disability claims. There is sufficient and adequate information on the medical report forms.

Concerning any other comments in connection with the social security disability program, he said he does not believe that doctors

should be legislated into providing medical reports for the Government without cost. He said the doctors have other medical report forms to prepare for insurance companies, civil service, Blue Cross, industrial accident, etc., all of which is time consuming.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed at his home on December 30, 1959. The doctor stated that he did not furnish any medical reports on disability applicants during the last month and can recall processing only three or four since January 1, 1959. The doctor personally spends from 30 to 45 minutes in preparing the report and making the examination. After briefly looking over the medical report form, he stated that he has no criticisms of the report form and that it is better than the reports he is asked to furnish insurance companies.

The doctor feels that a current examination is always necessary before furnishing a medical report for a social security disability applicant; he indicated that one of his patients had presented him the same report on several occasions and that in this case he merely filled out these additional reports based on the initial examination and report. The doctor feels he should be compensated for making a medical examination and filling out the report form; however, he stated with reference to the above case, that he did not charge the patient for merely filling out the report form. The doctor believes the Government should bear the cost of the medical examination and the report in those cases where disability applicant is unable to pay because of insufficient funds.

Dr. ——— had no criticism of either the Social Security representative or the State vocational rehabilitation employees. He feels that he has been furnished adequate information as to what kind of medical evidence he is to submit in connection with social security disability claims.

The doctor related the circumstances surrounding a medical report he had submitted for one of his patients. He stated that he had processed a medical report for this patient quite sometime ago and that the patient had also submitted additional medical reports from a hospital and other doctors. The doctor questioned the necessity of the patient having to submit to two more medical examinations arranged by the Social Security Administration when specialists from the hospital had submitted medical reports previously on behalf of the applicant. The doctor also questioned the fact that his patient had to wait over a year before he finally received disability benefits.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— at his office on December 21, 1959. It was necessary to wait about 1¾ hours after the time of the appointment due to the number of patients waiting. The doctor was cooperative and glad to help the subcommittee. He stated he has approximately 6 requests monthly for medical reports for social security disability applicants, that filling them out requires between 30 minutes and an hour, and he has no criticism of the report form.

He said it was difficult to state, except in specific cases, when a current physical examination should be made; and it would depend on the past record, changes, and how recent the doctor had made an examination.

He did not believe, the doctor should be compensated for filling out the medical report, but if there was a charge for this or a physical examination, the patient should make payment.

He believes that both the Social Security office and the State rehabilitation agency are too "lenient" and urge unqualified applicants to file. He doubted he had adequate information as to the kind of medical information he should furnish in connection with social security disability claims. He said the forms are furnished without any instructions. The doctor suggested that all original examinations of applicants should be made by a clinic or center, which would save both time and expense for the applicant. He also believes that a limitation by the State agency as to the extent of examination or fee should not be permitted.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I kept an appointment with Dr. ——— at his office on December 22, 1959. He received one request last month to furnish a medical report for a social security disability applicant. He said that it would take him about ½ hour to prepare a report for a disability applicant. Dr. ——— said that if the applicant is a patient of his and under current treatment, an examination would not be necessary. In general, he believed the patient should pay because he has the responsibility for furnishing the information to Social Security.

Dr. ——— criticism of the medical reports required in connection with social security claims was: (1) the form is adequate in scope only in those cases which are obvious or clearly chronic, and (2) in cases which require a determination for permanent and total disability, the form is not adequate because of the numerous and varied causes for such disability.

The doctor did not have any criticism of either the Social Security representatives or the State vocational rehabilitation employees since he has had no experience with them.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ———, a resident physician, on December 16, 1959.

Dr. ——— did not receive any request from a disability applicant during the prior month for a medical report. The doctor estimated that it has taken him approximately 30 to 45 minutes to complete a medical report. He suggested that the medical report required in connection with social security claims would be more useful if an address or telephone number was shown on it. Any problems which occurred could then be readily resolved without the loss of too much time.

Dr. ——— stated that if a patient was under his continuous care, a current examination would not be necessary before filling out a medical report. However, if the patient hadn't had an examination within 6 months, a current examination would be necessary.

Dr. ——— felt that he should be paid for filling out any medical report. If the Government requested a report, he believed that they should make the payment. He also felt that if a current examination was necessary to provide information for a claimant, the Government should pay for the examination.

Dr. ——— did not criticize the Social Security representatives he had dealt with. However, he felt that he could not get the information he needed from State vocational rehabilitation employees as directly as he would like. The doctor did not recall receiving any information from Social Security regarding the disability program. He emphasized that he felt that doctors should be informed of the part they play in the disability program. Dr. ——— stated that he would be interested in knowing the answers to the following questions:

- (1) How are disability claims processed?
- (2) Who determines whether an applicant is entitled or not entitled to disability benefits?
- (3) What rehabilitation facilities are available to aid applicants with an impairment?

I advised Dr. ——— to ask the Social Security office for the answers to his questions.

He also felt that State rehabilitation agencies set standards which were too rigid. He would like to see more lenient standards, so that more people could be helped by the program.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I met Dr. ——— on December 23, 1959, after a previous unsuccessful attempt.

The doctor hasn't had the occasion to fill out a medical report for social security during the past month; in fact, he could not remember ever doing so. After reviewing the form briefly, Dr. ——— estimated an hour would be necessary to properly complete the report. He stated he felt this length of time would be required because in all cases a current examination should be made before completing the report. Dr. ——— believes doctors should be compensated for filling out medical reports because as he stated, time is involved, and after all, time and service are the only items a doctor has to sell. The doctor thought the Government should pay both the cost of the medical examination and filling out the medical report form.

The only criticism the doctor offered in reference to the medical report form itself was that perhaps it might not prove specific enough in some cases. He stated this could easily be rectified by attaching a narrative statement for more detail.

Dr. ——— withheld any adverse comments on his dealings with either Social Security or State vocational rehabilitation agency representatives. His contact with either group had been so infrequent, he stated, he did not feel qualified to do so.

From my conversation with Dr. ——— it became readily apparent that the doctor was not familiar with the disability program. He was not aware of any distinction between the two programs, old-age and disability.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed on December 11, 1959, at his residence. Dr. ——— explained that he retired from practice in June 1959 and therefore had not filled out any of the social security medical reports in the past month. He could remember filling out only one of the forms during his entire practice. He said it would take about 45 minutes of his time to fill out the report. He had no criticism to make about the form and commented that it was not too detailed and was quite clear.

Dr. ——— said he could not think of any circumstances which would make a current examination necessary. Generally, a patient is one of long standing and a current examination is not necessary. He said that people do not just drop in to have the form filled out. Dr. ——— said he believed a doctor should be compensated for filling out the form and he thinks the Government should pay it. He also believes the Government should pay for a current examination if it is necessary.

Dr. ——— said he did not have any criticism to make about his dealings with Social Security representatives or State vocational rehabilitation employees. He had no suggestions to make regarding information received.

Dr. ——— said he believes the disability program to be a "wonderful thing" but believes that if the Government's own staff of doctors did the work, they would get a better job done. He said a family doctor might tend to be a little lenient in filling out the form.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I kept an appointment with Dr. ——— on December 28, 1959. The doctor stated he could not recall furnishing any medical reports for social security disability applicants since the initiation of the program. However, he said that he recently received a request to furnish a medical report for a disability applicant. Because of the doctor's reference to local Government-aid programs and his apparent unfamiliarity with the social security medical report, I showed him a copy of the report and asked if he wished to express an opinion as to its adequacy. The doctor stated that it seemed quite reasonable in comparison to others he is requested to provide. He estimated that it would take approximately 20 minutes to prepare the report.

The doctor feels that in all circumstances a patient should be given a current examination before providing a medical report. He questioned how a doctor could fill out the section entitled "Present Condition" without making such an examination.

Dr. ——— believes that he should be compensated by the patient for filling out a medical report form and providing a current medical

examination. He feels that if he were to be compensated by the Government reimbursement would involve too much redtape.

The doctor stated that he has very little contact with Social Security representatives or State vocational rehabilitation agency employees. He feels that the medical report form adequately describes the information desired in connection with social security disability claims.

Dr. ——— again referred to his unfamiliarity with the social security program when asked to comment thereon; however, he believes that it is a necessary social program to provide for the aged and disabled and he recognizes the responsibility of his profession in preparing medical evidence of disability.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed the doctor on January 7, 1960. Dr. ——— received six or eight requests during the last month to furnish medical reports for social security disability applicants. He and his secretary require about 15 minutes each to prepare a report for an applicant. The doctor had no criticism of the report except that he thought there could be a little more room for remarks.

Dr. ——— felt that as a general rule he should give the patient a current examination before providing a medical report if more than a month has elapsed since the previous examination. He also felt he should give one in any other case in which he thought the disability warranted a more recent examination.

The doctor does not charge for a medical report but was of the opinion a nominal charge should be paid by the patient if he was not already being treated by the doctor. Dr. ——— also believed the patient should pay for the current medical examination for the report since he is the one who will receive benefits.

Dr. ——— had no criticism of his dealings with either the Social Security representatives or the State vocational rehabilitation employees. He felt, however, that Social Security could specify more clearly the medical information it desires from the doctor. He believed if they did this, the doctor could be of greater service. Dr. ——— did not see how the people who are receiving disability benefits would get along without them and was of the opinion the program was functioning pretty well.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I kept an appointment with Dr. ——— on December 21, 1959. He is a general practitioner and estimated that last year he received at least three or four requests to furnish a medical report for a social security disability applicant.

He requires less than 20 minutes to prepare a medical report for an applicant. The doctor feels that a current examination is necessary if he has not examined the applicant recently. Dr. ——— does not charge his patients for filling out a medical report. He believes that furnishing the report to Social Security is primarily the responsi-

bility of the patient and if a current examination is necessary, the patient should pay for it.

The doctor said that the medical report form furnishes him with adequate information as to the particular medical information he is to furnish.

Dr. ——— commented that he had treated a patient for a long period of time. The doctor said that this man was blind in one eye, had suffered one or two strokes, and had an arthritic condition. The patient owned an insurance policy and met the work requirements for a social security disability benefit. The patient applied to the life insurance company and to Social Security for disability benefits about the same time.

Dr. ——— made the required examinations for Social Security and for the insurance company. He found the applicant to be permanently and totally disabled and so reported to both insurers. The insurance company promptly paid the insured the benefit amount of the policy. Social Security denied disability benefits to this applicant because of their determination that the applicant was not disabled to an extent which would preclude the possibility that he could work in some gainful occupation. Dr. ——— said that his patient talked to him concerning the denial of disability benefits. The doctor surmised that a representative of the district office told the claimant that he was denied disability benefits because a doctor other than Dr. ——— had determined that he could do some kind of work. The applicant blamed Dr. ——— because he had not written the medical form to the effect that his patient could not do any kind of work.

Dr. ——— stated that it was his strong belief that a well-founded statement that a claimant is permanently and totally disabled should be sufficient for the payment of social security disability benefits. He pointed out that particularly in cardiac cases some activity is recommended, and he mentioned the possibility that a beneficiary might limit his activity because of the fear he might be seen and as a result lose his benefits.

The doctor expressed his conviction that the gainful work idea had a generally bad effect on the disability program. He said that few industries would hire even partially disabled persons, and he believed the law should be changed. The change would express the requirement for permanent and total disability and omit "any gainful occupation" entirely. He said that most severely disabled persons never recover anyway after age 50.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed on December 18, 1959, at his office. He said he had received one request during the last month to furnish medical reports for a social security disability applicant, and that it requires about 20 minutes to prepare a report. Dr. ———, an eye specialist, said he always examines the patient before providing a medical report but that he does not believe he should be compensated for filling out a medical report for his patients. In the event a current medical examination is given, he feels that the patient should pay for it.

Dr. ——— did not criticize the medical report form required for any Social Security and State vocational rehabilitation employees. He said he feels that he has been furnished adequate information as to the kind of medical information he is to furnish a social security disability applicant. Dr. ——— said he thinks the social security disability program is a worthwhile program.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— on December 30, 1959.

The doctor recalled filling out one social security medical report form during the past month, and to the best of his knowledge he believes he completed only four during his entire practice. Dr. ——— emphasized that the time required to complete the form would depend upon the nature of the patient's impairment and whether a current examination was required. He felt strongly that a current examination should be a prerequisite to completing the report unless the patient had been in the office during the past 2 weeks. Dr. ——— stated that many patients come into his office with medical reports from insurance companies, et cetera, having last visited him years before and in a matter of minutes expect to receive a complete medical history report. The doctor also added that some parts of the medical report form call for tests which the average doctor is not equipped to perform in his office but must resort to the facilities of a hospital—this of course is time consuming. Dr. ——— informed me that he received one medical report form requesting that he supply medical information for a person for whom he had no records. He later learned that he had seen this individual during the time the individual was hospitalized, and consequently the hospital had the records. Some of his colleagues have experienced the same difficulty, he advised me. Dr. ——— realized that this was undoubtedly the fault of the applicants in directing their requests for medical information rather than the fault of the Social Security Administration.

Dr. ——— does not think the doctor should be compensated for merely filling out a medical report, but he does believe a fee is in order when an examination is needed as happens in over 90 percent of the cases. The doctor was in favor of letting the patient pay the fee.

The medical report form is a good one, Dr. ——— remarked, but believed it necessary to attach a narrative statement under many circumstances. Dr. ——— did not express an opinion as to what type of treatment he received in dealing with Social Security representatives or State vocational rehabilitation personnel since his contact with either group has been rather limited.

Dr. ——— believes he is well aware of the type medical information Social Security desires in connection with their disability program. He feels he must have given them what they wanted in the past since none of his reports were ever returned to him.

When I asked the doctor if he had any other comments relative to the social security disability program, he stated he feared the program was here to stay and would probably spread. Dr. ——— expressed concern over national hospitalization insurance being taken

over by the Government and wondered how far we were from socialized medicine.

Dr. ——— stated that he heard many persons, some of whom were his patients, say that the standards established by Social Security to qualify for payments were too rigid and you practically had to be dead to meet them. The doctor stated that he didn't think the standards too strict. To liberalize them would result in many more persons getting a "free ride" than at present. Dr. ——— stated he had experience with these "freeloaders" in handling some cases for one of the larger insurance companies and also for the State workmens compensation board.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed on December 15, 1959, at his office. At the start of the interview Dr. ——— explained that he would not be of much help because he is a dermatologist and does not receive many requests to provide information to Social Security. He usually refers the forms to general practitioners because he believes they are the only doctors that can fill them out adequately.

Dr. ——— said he had not filled out any of the medical reports during the past month and could not remember the last one. After looking at the form, he said it would take about 30 minutes of his and his secretary's time to prepare it. His only comment on the form was that it was not broken down into specialties. He would be able to fill out very little of the information requested. He said, for example, that he never measures a patient's height or weight.

Dr. ——— said that whether or not a current examination would be necessary would depend upon the time of the patient's last visit. He said that, with many exceptions, if a month or more had passed since the last visit, a current examination would be necessary. Two exceptions, he said, were if a patient had had an amputation or if he had an illness that was getting progressively worse.

Dr. ——— said he believed he should be compensated for filling out the form and, because the patient will benefit as a result, that the patient should pay for it. If a current examination is necessary, he believes the patient should pay for it if he is able; otherwise the Government should pay for it. Some cases, he said, he would be glad to do for nothing.

Dr. ——— said he did not recall any contact with Social Security representatives or State vocational rehabilitation employees. Other than the social security medical report he had not received any information.

Dr. ——— said he believes that a lot of people will take advantage of the disability program. He thinks there will be people drawing benefits who are not actually disabled. A reason for this was not given.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

After contacting Dr. ——— by telephone, I met with him on January 6, 1960. The doctor stated he could not recall specifically how many requests he had received during the last month to

furnish medical reports for social security disability applicants but estimated that he receives five or six requests a month on the average. The doctor stated that in addition to his secretary's time and the hospital's time in locating records, it takes him a minimum of 30 minutes to fill out the required medical report.

Dr. ———, a general surgeon, feels that he should make a current examination if he has not examined the applicant within the last 90 days. He stated that frequently he receives a request for a medical report in the mail from a patient not treated by him for quite some time, and in these cases he merely discards the report since he is "not in the mail order business."

The doctor "most definitely" feels that he should be compensated for filling out the medical report form and was equally emphatic about the Government paying for it. He stated that he does not know of any Government employees who work without being compensated and questioned the right of the Government to request the medical profession to do so. The doctor indicated that when he has tried to charge patients for filling out the medical report they have told him the report is not for them but for the Government. He also stated that he receives from \$5 to \$7.50 from private insurance companies for filling out much simpler medical reports for claimants. The doctor stated that these are not only his feelings but those of many of the people in the profession, and called over a Dr. ——— a general practitioner, to comment on the subject. This doctor felt substantially the same way in regard to being compensated for the report.

Both doctors feel that if a current medical examination is given, the patient should pay for it since the patient is to gain from both the benefits and the current medical data on his condition.

Dr. ——— had no specific criticisms of the initial medical report form but sharply criticized follow-up reports sent to him. He stated that upon indicating on the initial report that a patient is not ambulatory, he receives another report requesting fine distinctions in the degrees of movement and deflection in the various appendages with such questions as, "Is the applicant's right arm limited to 50 or 60 percent deflection?" The general practitioner criticized the portion of the initial medical report form which requests dates of such reports as X-rays, electrocardiograms and laboratory or diagnostic tests; the doctor stated that obtaining dates of such reports is too time consuming and that objective findings should be accepted on the assumption that the doctor made these tests. Dr. ———, as a general practitioner, feels he is unqualified to fill in the portion of the report pertaining to applicants' visual abilities. Dr. ——— stated that he never fills in the above portion of the initial medical report form, stating that it is obviously intended for an "eye man."

Dr. ——— had no criticisms stemming from his dealings with Social Security representatives or State vocational rehabilitation employees; he feels he is adequately informed as to what kind of medical information he is to furnish in connection with social security disability claims.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— on January 5, 1960. The doctor receives about one request a month to furnish medical reports for social security disability applicants. It takes the doctor about 30 minutes to prepare the report. He had no criticism of the report and felt that it was adequate. Dr. ——— believes that he should always give the applicant a current examination before providing a medical report.

The doctor does not charge for the medical report but is of the opinion that there should be a nominal charge for it. He stated that he, as well as other doctors, were receiving so many reports to fill out that it was taking up a lot of their time. He had no opinion as to whether the applicant or the Government should make the payment. He felt, however, that the patient should pay for the current medical examination since he thought this would deter the filing of false claims.

Dr. ——— had no criticism of his dealings with either the Social Security representatives or the State vocational rehabilitation employees. He feels he has been furnished adequate information as to what kind of medical information is desired in connection with social security disability claims.

The doctor believes that the applicant's medical examination should be made by a doctor other than the family doctor, especially in a small town. He thinks that perhaps it would be best if the examination were made in a different locality. He stated that in denial cases there was a tendency to blame the family doctor for not making the medical report strong enough.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— in his office on December 22, 1959. He is a physician and surgeon. His wife, who is his nurse, is a physical therapist. He specializes in treatment of chronic illnesses, and he feels that he is adequately equipped to perform diagnostic and laboratory tests and to treat many of these ailments. He took me on a brief tour of his office layout. I saw five separate examination rooms each of which had equipment and apparatus for treatment of specific ailments. He referred to this as his "small clinic." He was enthusiastic about the interview; gave considerable thought to each of my questions; and emphatically stated his comments. I found him to be well informed on the procedures and requirements of the disability program. He said, that beginning in 1955 and for a period of about 2 years, he was employed as a reviewing physician by the State rehabilitation agency. From 1956 to 1957, approximately 1 year, he was employed as a reviewing physician for Social Security. He is also a consulting physician for the veterans' hospital.

He received 10 requests last month to furnish medical reports for social security disability applicants. He showed me three medical reports that he was presently working on. He averages about eight

requests a month. It takes him from 20 minutes to an hour to complete the medical report. He attempts to give as complete a medical history of the patient as possible. He does not think that the medical report form is adequate. He believes the form is not detailed enough and that it should be changed to conform to a hospital type report. He suggested the following specific changes in sections 3 and 8 on the medical report form: (1) Section 3a should require a medical history of past and current illnesses, (2) the objective findings (sec. 3b) should be broken down according to systems of the body, head, neck, chest, and abdomen, and additional space should be provided in this section to allow for adequate description of diagnostic tests, laboratory tests, and all other similar medical evidences, (3) under "Remarks," section 8 of the medical report, the doctor should be required to summarize all the medical evidence in the case in order to present to the reviewing physician a complete picture of the disability applicant's physical condition. This would help the reviewing physician in making his determinations.

Dr. ——— believes that a current medical examination is necessary unless the patient has been examined by him within the last 30 to 60 days and provided that he has sufficient medical history on the patient and that all necessary diagnostic tests have been made.

The doctor believes that he should be compensated for filling out a medical report for his patients, except where the patient is a hospital case. He believes that the Government should pay for the preparation of the medical report and the cost of the current examination needed for such reporting. He said that the Government ends up paying for the medical evidence in most cases anyway. He thinks that under this procedure, the Government will save money in the long run and will be able to expedite the processing of claims. He maintains that the bottleneck in processing claims is caused by the lack of or insufficiency of medical evidence submitted by the patient's doctor. In his experience as a reviewing physician for both the State rehabilitation agency and Social Security, he found that the medical reports contained few symptoms; some reports showed no physical examination and many other reports did not show the extent of follow-up treatments (treatment schedule) or give evidence of diagnostic tests. The doctor stated that it was his opinion that this type of evidence is not available in many cases because the patients cannot afford to pay for the examination and the tests. Because of the inadequacy of the medical evidence submitted, the reviewing physician cannot make a determination, and the Government therefore has to purchase the necessary additional medical evidence at a later date. In the doctor's estimation, this procedure is not only costly, but it also creates additional paperwork and prolongs the processing of claims. In initially paying for the examination the Government could direct the type of examination to be given by the family physician and the extent of his diagnostic tests, if necessary. Dr. ——— believes that this can be accomplished by setting up flatrate working agreements which will be acceptable to the majority of doctors; such agreements would permit the patient to go to his doctor and receive an appropriate examination. He believes that the family physician is in the best position to determine what diagnostic tests are necessary for

submission as medical evidence to describe the claimant's disability. He believes that this procedure will also result in better adjudications.

He stated that the Social Security representatives in the district offices should be instructed not to recommend, suggest, or intimate to the disability applicant what doctor he should consult nor to encourage the applicant to consult a doctor other than his own. He mentioned that several months ago he wrote a letter to the manager of the local district office, and complained that on specific occasions certain of the representatives had encouraged his patients to consult other doctors. He regarded this action by the district office as a breakdown of doctor-patient relationship. The manager has since taken corrective action, and Dr. ——— is satisfied that this condition has been remedied. The doctor also complained that he has been a member on the State board of specialists examining physicians but has not had a disability applicant referred to him for examination in the past several years. He believes that these referral cases should be distributed equally among the board members. He believes that partiality is being practiced.

He does not feel that he needs any information as to the kind of medical information that is to be furnished in connection with social security disability claims. He reiterated that the present requirements for medical evidence are not adequate.

He said that "the best way for the Government to save money and to expedite the processing of claims is to hire, at a fixed fee, a panel of doctors in every large city." This would be similar to the Veterans' Administration practice. If the initial examination by the family physician is not conclusive enough for the reviewing physician then the applicant should be given a clinic-type examination by the panel of doctors. The final determination will be based on the findings of this panel. He believes that this will result in a fair and more equitable treatment of the disability application and will eliminate a lot of paperwork now being generated.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed at a clinic on December 15, 1959. He said he had received two requests during the last month to furnish medical reports to applicants for social security disability benefits and that it takes him about 25 minutes to complete a medical report form. He thought the medical report forms required to support social security claims were adequate.

Dr. ——— said that if the patient has not been examined within the past 6 months, it is the usual custom to make an examination. He said he believes the clinic should not be compensated for filling out a medical report but that if the patient visited him at his private office, he might wish to make a charge for the services. He said that if a current medical examination is given, the Government should pay for it.

Dr. ——— said he had no reason to criticize any of the representatives of the Social Security or the State vocational rehabilitation offices. He said he had been furnished adequate information as to

the kind of medical information he should furnish on the medical report forms but that his examinations are limited to tubercular patients. He had no general comment to make about the disability program.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed on December 16, 1959. He said he had received only one request for a medical report to support a social security disability claim and that it took about 30 minutes to prepare it.

Dr. ——— said that he always gives the patient a current examination before providing a medical report. He believes he should be compensated for filling out a medical report and that the patient should pay for the report as well as the examination.

Dr. ——— had no criticism of the medical reports required in connection with the social security claims, the Social Security representatives, or the State vocational rehabilitation employees. He said he feels he has been furnished adequate information as to the kind of medical information he is to furnish in connection with social security disability claims.

Dr. ——— had no comments on the social security disability program.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed on December 18, 1959, at his office. Dr. ——— said that during November 1959 he did not receive any requests to furnish medical reports for social security disability applicants. He only received about three or four requests a year. He said the average length of time required by him to prepare a medical report for a social security disability applicant has been about 30 to 40 minutes.

Dr. ——— said the only criticism he had of medical reports required in connection with social security disability claims was that it had been very hard to give adequate answers in the allotted space. Dr. ——— said he feels that he should give the patient a current examination before providing a medical report in cases where he has not seen the patient for the past 60 days.

Dr. ——— believes he should be compensated for filling out a medical report form for his patients. He said that in most cases the patient should pay. However, if the patient is indigent the Government should pay. He said if a current examination is given the patient should pay for it unless, of course, he is unable to pay because he is not working.

Dr. ——— said he had not had any contact with Social Security representatives or State vocational rehabilitation employees. He said the social security medical report form has provided adequate information as to what kind of medical information he was required to furnish.

Dr. ——— only other comment on the social security disability program was that he believes the disability program is good as it helps those in need who are otherwise unable to support themselves.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— in his office on December 29, 1959. He stated he had not received any requests in the past month to furnish medical reports but is associated with a group of four doctors in the office, and they would average about 10 requests a year. He also stated it takes him and his secretary about 1 hour to prepare the medical report. He had no criticism of the report form.

The doctor feels a complete physical should be given if the individual is not his patient, hasn't had one in the prior 6 months, or there is an apparent change in symptoms.

Dr. ——— does not believe the physician should be compensated for filling out a medical report from file history. In any case, he believes the patient should pay unless indigent. He also stated there should be a maximum charge of \$5 for examination of applicants sent by the State rehabilitation agency.

The doctor had no criticism of his dealings with either the Social Security office or State employees. He thought he had been furnished adequate information as to the kind of medical information required on the report form and had no other comments on the program.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— on January 6, 1960, in his office. He stated he had about 6 requests in the past month for furnishing medical reports for social security applicants. He said the time required for preparation of the report and the examination is in excess of 1 hour. He had no criticism of the medical reports required.

The doctor said that he felt a current examination should be made in nearly every case prior to providing a medical report. Dr. ——— believes that the doctor should be compensated for preparation of the medical report by the patient and that the applicant should also pay for a physical examination.

Dr. ——— has not had any contact with either the Social Security representatives or State vocational rehabilitation employees. He feels there is sufficient data on the medical report form to enable him to furnish adequate information on disability applicants. His only other comment was the difficulty in explaining to the applicant what is required to qualify for complete disability and making the applicant understand his explanation.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— in his office on December 28, 1959. He stated that he received no requests to furnish medical reports for social security disability applicants last month. He said that he received approximately three such requests during the calendar year. He estimated that it takes him about 20 minutes to complete the medical report. He stated that he had no criticisms of the medical report and that he had found it to be fair.

Dr. ——— stated that he believes that a current examination is necessary prior to furnishing a medical report unless the disability

applicant has been recently examined by him. He said that the patient should pay a fee of \$2 for the preparation of the medical form and that the patient should pay the cost of a current examination since the patient is the one who will benefit by it.

Dr. ——— did not have any criticisms of either the Social Security representatives or the State vocational rehabilitation employees. He mentioned that he gets a few reference cases from the State agency. He said that he did not need any additional information as to the kind of medical information that is to be furnished in connection with social security disability claims. He emphasized that he completes the medical report based on his findings.

Dr. ——— mentioned that sometimes he has found the decision of the referee to be impractical. He cited a case in which he represented his patient at a hearing. He said that according to his findings the patient, who was 63 years old, had a serious heart condition and was unable to work. At the hearing the referee stated that the applicant could operate a passenger elevator. Dr. ——— said that he told the referee that "there wasn't one elevator in the entire town where the applicant lived." He said he pointed out the impracticability of a 63-year-old man with a serious heart condition being able to obtain such a job. He informed me that the applicant's claim was denied. He emphasized that sometimes the determinations are based strictly on legal points without considering the practicality of the solution.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— on December 30, 1959, at his office. Dr. ——— is a general practitioner. He said the general practitioner is allowed only \$7.50 by the State vocational rehabilitation agency for examinations requested by them for disability applicants, whereas specialists are allowed \$25. He said he is not permitted by the State to do rehabilitation surgery although he has full hospital privileges. He said he knows of cases where he has made out a medical report and definitely stated the individual was not "permanently disabled," and the patient was sent by the State agency to another doctor "to get a favorable report." The doctor apparently has a good practice and from conversation of the patients waiting in his office, the community has confidence in him. He was rather severe in his statements about the State agency and their nonacceptance of his reports.

Dr. ——— averages about four requests monthly for medical reports for social security disability applicants. He said the time required to complete the report depended on whether it was one of his local patients or a new case but in all cases it takes in excess of 1 hour. He had no criticism of the medical reports required in connection with social security claims. The doctor's opinion is that a complete physical examination should be made of the applicant at the time of his application for social security disability.

He does not believe the doctor should be compensated for preparation of the medical report form but believes if a charge is made for either preparation of the report or an examination, the applicant should make payment.

His criticism was not of Social Security office or its representatives, but of the fact they are a party in each case where he stated the State vocational rehabilitation personnel "wield the big stick," and he commented that individuals and political influence at the State level play an important part in approval or disapproval of applications.

He said he had not been furnished any information as to the kind of medical information desired in the medical reports. The medical reports are received in the mail without any explanation.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— at his office on December 29, 1959. Dr. ———, who is quite elderly, advised me that he was semiretired and had restricted his practice to office calls. He said he had no requests to furnish medical reports for social security applicants last month. He stated that during the calendar year he prepared only one medical report which he submitted in June 1959. He estimated that it takes him an average of 30 minutes to complete the medical report. He did not have any criticisms of the medical report.

Dr. ——— stated that a current examination is necessary prior to furnishing a medical report except where the disability applicant is his patient and has been examined by him within the past 6 months. He said that he does not feel that he should be compensated for filling a medical report form for his regular patients. He pointed out that the Government should pay for a current examination only when the patient is unable to pay.

He had no criticisms of either the Social Security representatives or the State vocational rehabilitation employees. He stated that he felt that he had been furnished adequate information as to the kind of medical information required for disability claims.

He had no comments on the social security program. However, he commented on the denied claim of one of his patients, whom he had examined during the previous week. He stated that this was his first denial case so far as he could remember and that he felt that more consideration should have been given to the applicant's worsening condition. He pointed out that he had degenerative osteoarthritis of the left hip. Dr. ——— feels that in a short time the man may be crippled.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— at his office on December 21, 1959. He said that he received no requests to furnish medical reports for social security disability applicants last month. He stated that he received approximately six such requests during the calendar year. He estimated that it takes him an average of 20 minutes to complete the medical report. He said that a physical examination requires from 30 to 45 minutes. Dr. ——— said that the medical report was not difficult to fill out.

Dr. ——— emphasized that unless the disability applicant was a regular patient, he would require a current medical examination before completing the medical form. He added that if the patient had

not been examined by him within the last 4 to 6 months from the date that a medical report is requested, he would require a current examination. He stated that a fee equivalent to an office call (\$3) should be charged for filling out the report when a current examination is not required. He said that when an examination is required a minimum fee of \$5 should be charged. He reasoned that from a moral standpoint the patient should pay for the preparation of the form and the examination but that in some cases the patient, because of long illness and inability to work, cannot afford these costs. He said that from a practical point of view, the Government should pay for the preparation of the form and the examination when the patient is unable to pay.

Dr. ——— did not have any criticisms of either the Social Security representatives or the State vocational rehabilitation employees. He mentioned that he had practically no contact with either agency recently. He did not feel that he needed additional information as to the kind of medical information that is to be furnished in connection with social security disability claims. He emphasized that he completes the form based on his examination and medical history of the applicant.

He stated that he did not understand how Social Security makes some of its determinations. I got the impression that Dr. ——— did not know of the disability requirements, so I read to him the Social Security definition of "disability." He responded that to him the definition was "ambiguous." He said he knew several people who were turned down but who, in his medical opinion, should have been allowed a disability pension. I mentioned to him that approximately 20 minutes earlier I had interviewed Mr. ———, his patient, who had a hearing on his case and whose claim was recently denied. Dr. ——— emphasized that he could not understand why the man's claim was denied. He said that he was surprised that Mr. ——— is still living today. He informed me that Mr. ——— had a bad heart and could not work. He said that Social Security feels that he could do certain jobs. Dr. ——— said that he agreed with this statement but that it is impossible to find the specific job with the special work limitations required. He mentioned that no employer is going to hire a man with a severe heart condition especially under the work limitations. He concluded that the disability program was Social Security's program and they could conduct it as they wanted.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

I interviewed Dr. ——— on December 14, 1959.

Dr. ——— recalled preparing one medical report for a social security disability applicant during the last month. It took the doctor approximately 30 to 45 minutes to complete the medical report. He had no criticism of the medical reports he was required to complete to support social security claims.

The doctor felt that a current examination was unnecessary as a basis for completing a medical report if the claimant was his patient and under his continuous care. However, he emphasized that even though the claimant was his patient, an examination would be necessary if the patient had not been examined within 6 months. If the

applicant was not his patient, the doctor felt an examination was necessary.

Dr. ——— stated that if a lengthy medical report was required by the applicant, he should be compensated for his time. Since his patients are not wealthy, he felt the Government should pay for the long medical reports. He also believed that if a current medical examination was required to support an applicant's claim to disability benefits, the Government should pay for it.

Dr. ——— did not criticize any of the Social Security representatives or the State vocational rehabilitation employees with whom he has dealt. He stated that he had never received any information other than the medical report itself and that the form was self-explanatory.

I thanked him for his cooperation.

INTERVIEW WITH DOCTOR

Dr. ——— was interviewed in his office on December 30, 1959. He said he had received only two requests during the last month to furnish medical reports for social security disability applicants, and that it requires about 30 minutes to prepare a report. He said he thinks all patients should be given a current examination before a medical report for a disability claim is prepared. Further, there should be no charge for completing a medical report form. Dr. ——— said that if a current medical examination is given in a clinic, no charge should be made but if given by a private doctor, the patient should pay for it.

As to medical reports required in connection with social security claims, he said they should be better organized; the present form is repetitious and not comprehensive as to the patient's history. For example, item No. 6 on the medical form is a difficult question; item No. 7 should be expanded to include cardiac findings; respiratory case history is very important and should be required; and there is insufficient room on the form to answer arthritis case questions.

Dr. ——— was not critical of either the Social Security representatives or the State vocational rehabilitation employees with whom he had dealt. He also said that, although he believed the medical report form in use could be improved, he had been furnished adequate information as to what kind of medical information he is required to furnish in connection with social security disability claims. He offered no general comments on the social security disability program.

I thanked him for his cooperation.

HOSPITAL OFFICIALS

INTERVIEW WITH HOSPITAL OFFICIAL

I met with ———, the assistant director of the hospital, on December 18, 1959. The assistant director informed me the hospital prepares between 20 and 25 medical reports a week for Social Security. This is not surprising because the hospital handles over a hundred patients a day in their clinic. He further stated that the preparation of the medical reports necessitates the review of the patient's entire medical record and therefore is very time consuming. His staff estimates it takes approximately 8 hours of administrative staff time to complete three reports.

Approximately 80 percent of the medical reports prepared for Social Security concern persons who were patients but who are not currently receiving treatment by the hospital. Only in rare instances are any of these subjected to current medical reexamination. This depends primarily on the nature of the condition which brought the patient to the hospital originally and the expected prognosis of the case.

Mr. ——— expressed the views of the hospital, as well as his own, that a fee should be set for the preparation of the medical report and that this cost should be borne by the Government since they are seeking the information. He added that over 90 percent of the patients visiting the hospital clinic could not afford to meet the cost anyway.

The assistant director criticized the medical report form unfavorably in that it is not specific enough as to the kind and extent of the information wanted. His staff has found on many occasions after completing a report, Social Security will again contact them seeking more information or a different type of information on the same case. He feels if they had been adequately advised in the first place, this could have been completed at one time. He also recalled several occasions when the staff mailed the completed report to the Baltimore address appearing on the report form when the proper destination should have been one of the district offices.

Mr. ———, in closing, informed me that nearly all the doctors on the staff of the hospital felt the doctor should have a greater voice in deciding whether an individual is disabled or not. It is their understanding when filling out one of Social Security's medical reports, they should insert their findings but avoid expressing any opinion as to whether they find the person capable of performing substantial gainful activity. They believe the examining doctor is in a better position to know his patient's capabilities than the members of Social Security who review the completed reports.

I thanked him for his cooperation.

INTERVIEW WITH HOSPITAL OFFICIAL

This dispensary is the outpatient department of a hospital. The dispensary averages about 65,000 patient visits a year and has 72 clinic beds in the hospital. The dispensary is primarily a clinic for the destitute in need of medical care. If a patient is financially able, he is charged \$3 for the first visit and \$1.50 for return visits.

Mrs. ———, R.N., clinic supervisor of the dispensary, stated that they receive approximately 30 requests a day for medical reports from various sources and that about 3 or 4 of these reports are in regard to social security disability claims. The medical report forms are prepared by clinical secretaries from the dispensary records on the applicant's medical history. She stated it takes about 15 minutes to summarize the information from the dispensary records. Mrs. ——— had no criticisms of the initial medical reports required in connection with social security claims; however, she criticized the followup requests she receives for more adequate information stating that the initial reports are filled in to the best of the clinical secretaries' abilities and the complete information in the file on the applicant is given at that time.

Mrs. ——— feels that under no circumstances should the dispensary make a current examination when furnishing a medical report for social security disability applicants. Mrs. ——— stated that the dispensary's professional staff consists of approximately 350 doctors who devote 2 hours a week to clinic work and that these doctors devote their time to care for indigent persons rather than spend their time filling out medical reports for the benefit of the Social Security Administration. She stated that when an applicant, who has not previously received treatment, requests the dispensary to furnish a medical report form, he is referred to his regular doctor.

Mrs. ——— stated that it would be wonderful if all Government agencies paid for the various medical report forms required by them since the applicants, in many cases, cannot even afford a 4-cent stamp for mailing the report. However, she stated that if the Government were to compensate the dispensary for filling out the report they would want better reports which would require her to hire additional staff. Mrs. ——— stated that the medical report is currently furnished as a service to the patient rather than to the Social Security Administration and that no matter what the Government would pay for preparation of the medical report it would not be sufficient to justify the hiring of additional staff. Mrs. ——— believes the Government should pay for the medical examination because many disabled people do not have the money to pay; however, she stated that even if the Government did pay, the dispensary would not make current examinations because its purpose is to serve sick people requesting treatment rather than reports.

Mrs. ——— did not have any criticisms regarding her dealings with either Social Security representatives or State vocational rehabilitation employees. She feels that the initial medical report form adequately describes the type of medical information required in connection with social security disability claims.

In commenting on the social security disability program, Mrs. ——— stated she is very interested in the proposed amendments to the law dealing with hospitalization benefits. Mrs. ——— stated this would be an aid to the ——— dispensary in meeting the high costs of medicines.

I thanked her for her cooperation.

INTERVIEW WITH HOSPITAL OFFICIAL

On December 22, 1959, I interviewed Mr. ———, assistant administrator of the hospital. Mr. ——— answered the questions with the help of employees from the insurance department which handles all requests for medical information.

Mr. ——— said it could not be determined how many requests were received during November 1959 to furnish medical reports for social security disability applicants. He said records have not been maintained to show requests received since June 1959 during which month 13 requests were received. No average for the year could be given. Mr. ——— said the average length of time required by a doctor to prepare a medical report for a social security disability applicant was 30 to 40 minutes. He said neither he nor the hospital staff had any criticism of the medical reports required in connection with social security disability claims.

Mr. ——— said he feels that a patient should be given a current examination if he has not seen his doctor for at least 30 days. Mr. ——— said he does not believe the hospital should be compensated for filling out a medical report for a patient because it is a service to the patient. The obligation is to the patient. This is a county hospital and 90 percent of the patients are financially indigent. He said that if a current examination were given a patient the patient should not pay for it. If the Government were to pay for it the hospital, he said, would have to fill out "400 forms"; therefore, it would be cheaper to examine the patient without cost.

Mr. ——— said he has had satisfactory relations with the Social Security representatives and the State vocational rehabilitation employees. He has no criticism of his dealings with them. He said he feels the hospital has been furnished adequate information as to what kind of medical information should be furnished in connection with social security disability claims.

He had no other comment on the social security disability program. I thanked him for his cooperation.

INTERVIEW WITH HOSPITAL OFFICIALS

The hospital furnishes about 45 medical reports a month to the State vocational rehabilitation agency. Although the hospital does not use the form furnished, hospital officials had no criticism about the form. The hospital furnishes two types of medical reports, one for inpatients and the other for discharged patients. The information for the report prepared for an inpatient is obtained from the attending physician and takes about 15 minutes to prepare. The medical report for a discharge patient is obtained by reproducing the medical summary from the patient's medical file which takes about 40 minutes.

Hospital officials stated that the determination as to whether a current medical examination was necessary, before preparing a medical report, was a question of medical judgment which must be decided for each individual case.

Hospital officials stated that there is a certain amount of expense incurred with every medical report furnished but that compensation for the preparation of the report would depend on volume. They believe that only indigent patients should not be required to pay for a medical report.

The officials had only one criticism relating to furnishing medical reports on inpatients. The State vocational agencies requires that the prognosis of an illness or disability be given; however, hospital officials stated that it was not always possible to give the prognosis on a patient because the patient is currently undergoing treatment which would determine the eventual outcome of the illness or disability.

The hospital officials furnishing the above information were the manager, the director of personnel, and the chief of hospital services.

I thanked them for their cooperation.

INTERVIEW WITH HOSPITAL OFFICIAL

Mr. ——— was interviewed on December 11, 1959 at his office. About halfway through the interview Mr. ——— called in Miss

——, medical record librarian. Mr. —— explained that Miss —— prepared the forms from the medical records and they were then approved by the doctor.

Mr. —— said the hospital had not prepared any of the forms during the past month and only four could be located that had been prepared since April 1959. He said it may take very little time to prepare some of the forms but that an average time would be about 1 hour.

There were four comments made about the form:

1. Mr. —— said that many times the form is hard to apply to the specific illness and suggested a letter form report would be better in some cases.

2. With respect to the first treatment date, Mr. —— said, they were not sure just what date was wanted—the date the patient was first treated at the clinic for any illness or the date that he was first treated for the current illness.

3. Mr. —— suggested that two copies of the form be sent so they could retain a copy other than a plain tissue copy.

4. For cardiac illnesses an American Heart Association classification is required. Mr. —— suggested that this be footnoted, giving the classifications, because it sometimes requires research to provide a correct classification.

Mr. —— said there was no objection to providing the information without a current examination because there is usually a complete record of the case on file. However, a current examination would be best if the claim is appealed.

Mr. —— said he believed that if a doctor's time is involved in preparing the form, there should be a charge made for it and he has also heard others express the same opinion. He believed that because the patient receives the benefit of having the form filled out, the patient should pay for it. If a current examination is necessary, he believed it should be paid for by whoever requests it, either the Government or the patient.

He did not have any criticism of his dealings with Social Security representatives or State vocational rehabilitation employees.

I thanked him for his cooperation.

INTERVIEW WITH HOSPITAL OFFICIAL

Mr. ——, manager of the Veterans' Administration hospital, introduced me to Mr. ——, assistant chief of the registrar division, who was to answer my questions concerning furnishing medical evidence for social security disability applicants.

Mr. —— gave me the following statistics representing the number of requests for medical reports for social security disability applicants since August 1, 1959:

August	71
September	70
October	61
November	61
December (as of the 17th)	42

Veterans' Administration (VA) Instructions, Circular No. 11, entitled "VA Cooperation with the Bureau of Old-Age and Survivors Insurance" provides that when a request is received for a medical report on a social security disability applicant, a copy of VA's Narrative Clinical Report will be furnished, if available. These reports are available if the applicant was hospitalized here. Mr. ——— stated that it requires about 15 minutes to process a request; the main problem is locating the records. He stated that reports have varied from 1½ pages to 12 or 13 pages. For those applicants who have not been hospitalized but who have received treatment, the hospital furnishes a summary of the treatment, showing diagnoses, operations, and other pertinent medical history and remarks. Preparation of this report requires about 15 minutes of clerical work in extracting and typing the information from miscellaneous records.

Because the social security medical report form is not used by the Veterans' Administration, Mr. ——— was shown the form and asked if he could make any pertinent comments. He stated that the report covers about the same information as VA reports; however, in a few particular cases the VA reports show information regarding respiratory maladies. Mr. ——— stated that usually no current medical examination is given.

Mr. ——— stated that copies of medical reports are furnished to other hospitals, both public and private; to lawyers; to insurance companies; and to other Government agencies, such as the Railroad Retirement Board, without any reimbursement by these recipients or by the individual involved. He stated that insurance companies are the largest recipients of copies of VA medical reports. He emphasized that the Government bore the initial cost of the reports, examinations, treatments, hospitalization, etc., because the applicant was eligible because of his veteran's status.

A field representative from the local Social Security district office visits the hospital once a week to process claims for benefits under the Social Security Act. Mr. ——— stated that the hospital has had very satisfactory dealings with the field representative and the Social Security district office. He further stated that the hospital has had very little contact with the State vocational rehabilitation agency.

The hospital furnishes information in accordance with VA instructions and Mr. ——— stated he can only recall two or three cases in the last 3 months, where requests were made for additional medical data, other than that originally furnished for social security disability applicants. Commenting on the social security disability program, Mr. ——— stated that the whole social security program is helpful to the hospital in discharging indigent patients.

I thanked them for their cooperation.

INTERVIEW WITH HOSPITAL OFFICIAL

Dr. ———, medical director and administrator, and Mrs. ———, medical records librarian, were interviewed on December 9, 1959, at the hospital.

Mrs. ——— said that during November 1959 there were 17 requests to furnish medical reports for social security disability applicants. The number varies each month, 21 being received in October, and 27

in September. Mrs. ——— said the average time required to prepare a report varied from 20 minutes to 1 hour.

Mrs. ——— said that a terrific load is placed on the hospital by individuals, State and Federal agencies, and others requesting medical letters and reports. She said she had a backlog of about 100 letters and reports for the month of November, among them about 12 from the Social Security Administration.

Mrs. ——— said it was her opinion that the Social Security Administration should employ a competent medical clerk, trained to interpret medical records and terminology. This would give the Administration faster service for a disability applicant and would take a burden off the hospital medical records section. She is the only employee who is servicing these requests for medical reports. This is in addition to her other duties.

Dr. ——— said that in the event of a request for a current medical report on a patient with prior hospitalization he would call for an examination of the patient before signing a medical report. Dr. ——— said he believes the hospital should be compensated for filling out a medical report if the request for such report is from private or commercial sources. In the case of Social Security Administration requests for medical reports, he believes the patient should not be charged.

Dr. ——— said he believes the patient should not be charged for a current medical examination and, as this is a tax-supported hospital, such examinations are made without cost to indigent patients. Therefore, asking the Social Security Administration to pay for these current medical examinations would be using additional tax money.

Mrs. ——— said her relationship with the Social Security representatives and State vocational rehabilitation employees has been cordial. She has no criticism.

Mrs. ——— has no complaints concerning the information furnished in the requests for medical information needed in connection with social security disability claims. She referred to her prior remarks concerning the employment of a medical clerk.

Dr. ——— said he was not sufficiently familiar with the social security disability program and could not offer any comment or criticism of its operation. Mrs. ——— had nothing to say in this regard.

I thanked them for their cooperation.

INTERVIEW WITH HOSPITAL OFFICIAL

I called on Mr. ———, administrator of the hospital, on December 17, 1959. Mr. ——— called in another hospital official to assist him in answering the questions. They suggested that I leave the questions with them and return on December 21, 1959, for the answers.

A summary of the information given me by the administrator of the hospital follows:

1. The hospital averages 30 to 35 requests monthly, for medical reports.
2. The average time to prepare a report for a social security disability applicant is less than 20 minutes.
3. Doctors feel a current physical is not necessary if patient has had treatment within the past 12 months.

4. The administrator believes they should be compensated, by the Government, for filling out the medical report.

5. The doctors believe the Government should pay for any physical examination required.

6. Neither the doctors or administrator had any criticism of the medical report.

7. Neither had any criticism of their dealings with Social Security or State vocational rehabilitation employees.

8. The administrator feels that adequate information is furnished to enable the hospital to comply with disability application requests. He had no comments on the social security disability program.

I thanked him for his cooperation.

INTERVIEW WITH HOSPITAL OFFICIAL

The hospital furnishes about 200 to 250 medical reports to the vocational rehabilitation office each month. The hospital completes the form by reproducing a portion of its medical file. The report only takes about 20 minutes to prepare but it sometimes is weeks before the hospital gets around to completing the report. The vocational rehabilitation office is going to assign an employee to reproduce the records in order to speed up the processing.

Hospital officials did not think it was necessary to have a current examination to prepare the report. They believed that a current medical examination would only be necessary on rare occasions.

Hospital officials thought that payment should be made for the report or medical examinations, if necessary. They believe the patient should be required to pay for the report or medical examination because he is the one receiving the benefits.

The hospital officials had no criticism of Social Security officials or vocational rehabilitation officials. I received the general impression that the hospital just reproduced portions of its medical file and the Social Security office could take it or leave it. I also received the impression that the vocational rehabilitation employees went to the hospital and examined the records rather than requesting additional information from the hospital.

The hospital officials furnishing the above information were —— the chief of the medical department and —— the associate administrative officer.

I thanked them for their cooperation.

INTERVIEW WITH HOSPITAL OFFICIAL

I kept an appointment with Dr. —— on January 11, 1960. He is a third-year resident in psychiatry in a hospital. In this capacity, Dr. —— prepares many reports for various institutions such as insurance companies and State and Federal agencies. He said that he cannot say specifically how many social security medical reports he has prepared in the last month because his records are not designed to disclose such information. He did say, however, that he estimates that he has prepared at least 12 social security medical reports in the last year.

The doctor said that the hospital makes no charge to any patient or to any social security disability claimant for the preparation of medical reports. He said that it takes him on an average less than 20 minutes to complete his part of the report.

I asked the doctor for any criticism he could offer about the medical reports required for disability claims. He replied that, in his opinion, sections 4, 5, and 6 (front of form) were not adequate for psychiatric reports; that there were not enough writing spaces provided to enable the examiner to explain his findings in sufficient detail. He did say, however, that he could always write a supplemental report; nevertheless, he stated his belief that the data presentation would be improved by having it on the single form.

He said that his experience with social security representatives was very limited; and he could offer no criticism of them. He stated that in his experience with State employees he had found them to be realistic in their approach and attitude. He offered no amplification of his statement. The doctor stated that he is furnished adequate information as to what medical information he is to furnish in connection with disability claims.

I thanked him for his cooperation.

INTERVIEW WITH HOSPITAL OFFICIAL

I made an appointment with the executive director of the hospital for December 17, 1959. Mr. ———, executive director, Mr. ———, assistance executive director, and Miss ———, administrative assistant were present at the interview.

Miss ——— estimated that approximately 25 medical reports were received last month from social security disability applicants. The average time required to prepare a report is 30 minutes. Each hospital official stated that the medical report form was detailed and did not leave enough space for a full explanation of the claimant's disability. Mr. ——— suggested that an additional comment page be attached to the existing form.

These hospital officials also agreed that the nature of the problem would determine if an examination should be given before a medical report was furnished social security. In many cases, hospital records only would be all that was necessary to complete a medical report form. They believed that the hospital should be compensated by the Government for furnishing the medical report because its preparation consumes the time of trained personnel. In addition, they believed that if a current examination was made of the disability applicant, the Government should pay for it.

The hospital officials did not criticize the social security or the State vocational rehabilitation employees. They stated that both agencies were very cooperative. Each of the hospital officials we interviewed felt that they had not been furnished adequate information as to the kind of medical information they should furnish to support social security disability claims. They are very interested in the program but had received very little information about it.

The hospital officials felt that Social Security should inform doctors about the disability program and should also emphasize the impor-

tance of properly completing the medical report form. The officials interviewed also said that they would like to see a standard medical report form used by all Government agencies as well as Blue Cross, insurance companies, etc.

I thanked them for their cooperation.

INTERVIEW WITH HOSPITAL OFFICIAL

This hospital receives about two requests a month to furnish medical evidence for social security disability applicants. The director of the hospital stated the hospital furnishes, without charge, a copy of the first page of the patient's medical chart. The first copy of the patient's chart lacks clinical and diagnostic details and this may account for the limited number of requests for medical evidence.

The director stated that they have never filled out the social security medical report and have not supplied Social Security with copies of the patient's detailed medical records.

The director stated the hospital should be reimbursed for the costs incurred if Social Security required copies of the patient's detailed medical records. The director stated that disabled patients generally could not afford to pay for services received. However, she did not wish to express an opinion as to whether the Government trust fund should pay for the cost of furnishing a disability applicant medical evidence.

She did not have any criticism of the hospital's dealings with either the Social Security representatives or the State vocational rehabilitation employees. The director did not have any other comments on the social security disability program.

I thanked her for her cooperation.

APPLICANTS RECEIVING BENEFITS

INTERVIEW REPORT

Applicant Receiving Benefits

Miss —— was interviewed on December 12, 1959, at her home. Miss ——, who lives alone in a fourth-floor apartment, was about to leave to see her doctor but courteously agreed to be interviewed before proceeding to the doctor. She was very cooperative. She has a slight humpback and she breathed heavily.

Miss —— found out about the disability program from her doctor and from a friend who was receiving benefits. She knew where the Social Security district office was, and she went there to file her claim. She had to wait about 15 minutes to talk to someone. She said that the claims representative treated her very nicely.

The claims representative, she said, did not explain much of anything to her except to say that it was not up to the district office to make a determination of her claim. The claims representative did, however, ask many questions in taking necessary information. She said she was neither encouraged nor discouraged about filing her claim, and that they apparently didn't want to get her hopes up.

Miss ——— said that the claims representative filled out the application for her and telephoned her several times about her medical proofs and birth certificate. The medical forms were mailed to her doctor, and she was not charged for their preparation. She had been going to her own doctor every 2 weeks and she did not have a special examination before, or after, she filed for benefits. She was not sure whether or not the district office received any reports from her doctor, but she thinks they did because they telephoned to find out what was causing the delay.

She did not feel that she needed additional assistance after she first talked to the claims representative. She only went to the district office once and she did not receive any assistance from any other person or organization.

She said she had no complaints and thinks she got all she was entitled to, and that there was no redtape, no quibbles, nor anything. I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

After some difficulty and after several inquiries I was able to find Mrs. ——— residence and thus keep our appointment for 4 p.m., December 14, 1959. Her home is a red shack located in an isolated wooded area. Access to her residence is almost impossible due to poor road conditions and three huge dogs she keep as pets. These dogs have been the sole source of her companionship since her husband abandoned her many years ago. Her impairment confines her to a chair most of the time and except for a few domestic chores and care of her personal needs the claimant's activity is very limited.

Mrs. ——— learned of the disability program through the newspaper. The local post office told her she would have to report to the armory to either inquire about her disability or to file an application. The ——— armory serves as a contact point for the district office where a Social Security representative sits 1 day a week to serve individuals in the immediate area.

The applicant stated that after waiting only about 30 minutes she was taken care of most courteously. She agreed that her rights under the program were explained but she did not fully understand all the details. Mrs. ——— remembers clearly the Social Security representative telling her that in order to qualify for benefits, the applicant had to be unable to do any work. He advised her to file an application after listening to her story, Mrs. ——— told me.

The claimant stated the Social Security representative actually completed her application while she answered his questions. She was given a medical report form which she took to her doctor as instructed. Her family doctor examined her as he filled in the medical report form. Mr. ——— claimed she was charged as if this were a regular visit. She gave the Social Security representative permission to obtain other medical information from a hospital where she had been confined.

Mrs. ——— was well satisfied with the treatment she received throughout the course of her case and added she could never have done anything without the extensive help she received from all concerned.

The applicant has not been able to work for 11 years.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I met with Mr. ——— at his home on December 29, 1959. Mr. ———, age 56, lives with his wife in a frame home in a rural area. The beneficiary, a carpenter, has not worked since March 21, 1959. I believe the beneficiary's comments were very frank and sincere.

Mr. ——— learned of the disability program from friends and of the location of the district office from the local post office. He stated that he visited the Social Security district office twice and on both occasions was treated courteously and did not have to wait long before someone talked to him. Mr. ——— stated that on his first visit to the district office, a woman representative told him that people try to take advantage of the disability program and quit working in order to seek early retirement. He stated that the woman told him he would have to be disabled for 6 months before he could be eligible for benefits and that he should come back after the 6-month period expired.

The beneficiary feels that the disability program and his rights under it were fully explained to him and stated he was also given pamphlets and booklets explaining the program. He stated the Social Security representative did not describe how disabled he had to be to qualify but processed his application upon his request and told him that he would be notified of the final decision in his case.

Mr. ——— stated that the district office representative filled out his application while questioning him. He stated the Social Security representative also gave him medical report forms and instructed him to have his doctors complete and submit them. The beneficiary stated he had two doctors submit medical evidence of his disability. Mr. ——— stated the doctors did not charge for the preparation of the report nor for the examination. He thought that only one of the doctors examined him at the time the medical reports were prepared. The beneficiary does not know if the district office obtained reports from other doctors or hospitals in regard to his case.

Mr. ——— stated that he did not feel he needed any additional assistance in regard to processing his claim and relied entirely on the district office representative's instructions.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I met Mrs. ——— on December 10, 1959, at the apartment of her sister. Mrs. ——— has apparently been the victim of many financial adversities since the death of her husband in 1941. She appears to

be a highly emotional person and started to cry several times during our interview.

Mrs. ——— first became aware of the disability program when actually applying for old-age benefits. The applicant, upon entering the United States as a refugee after World War I, gave the year of her birth as 1903 to make herself appear younger, and thereby, she thought improved her chance to remain in the country. When naturalized, she used 1903 again to avoid complications, rather than 1896 which she contends is her correct birth date. Social Security would not accept the earlier date and therefore rejected her application for old-age benefits based on the fact she was too young. The Social Security representative suggested she file for a disability after being turned down for old-age benefits. Mrs. ——— stated the same lady took care of her disability application—all she had to do beside answering questions was sign it. She thought this person one of the nicest and kindest she ever met.

The applicant stated she took medical report forms to her doctor and, although a regular patient, he reexamined her and completed the forms without charge. Social Security sent a letter to secure additional medical information to the hospital where she had once been confined for an operation. Mrs. ——— stated she gave Social Security authorization to do this and apparently it was done. Social Security sent her to two other doctors of their choice and neither charged her for their examinations.

The applicant stated after first talking to the district office she was bewildered and would have been at a complete loss without the wonderful person there who helped her so patiently. Mrs. ——— spoke very highly of Social Security and although receiving only \$33 per month, she is very grateful for it.

Mrs. ——— is not working now but attempted to do so in 1958, earning only \$8 a day. She still spoke of finding some type of employment, perhaps babysitting, but her highly emotional state, coupled with the many ailments she has, makes employment of any type seem remote.

The applicant complained bitterly of how she is treated when visiting the hospital clinic which according to her is supposed to give medical aid to persons who cannot afford to pay. On the occasions she is able to reach there, she is kept waiting hours before being treated, and then most discourteously. She stated the people are herded like cattle in a most degrading manner.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I met ———, a 56-year-old applicant, at his home December 17, 1959. It was in a semislum section where many of the immediate surrounding houses were condemned. His impairment left him almost totally blind and restricted his movements to a slow shuffle when attempting to walk.

Mr. ——— stated he first learned of the disability program through a neighbor and the same neighbor phoned the district office for him

since his blindness prevented him from doing so. The applicant's disability made it impossible for him to visit the district office; therefore, a Social Security representative brought the application to his home and filled it out after asking Mr. ——— questions. He stated the gentleman was most kind and patiently explained his rights under the program. Mr. ——— stated he was told his disability had to be bad enough to prevent him from doing any substantial work. He further implied he was neither encouraged nor discouraged from filing but the decision was left to him.

The applicant stated he did not get medical proofs himself but he remembered signing an authorization so that Social Security could obtain them from the hospital where he had been a patient for some time. He added he was not charged for this.

It was very obvious upon looking at Mr. ——— that he is unable to work. He has no complaints relative to his treatment at Social Security; however, he gives the impression he feels a slight degree of security now that his checks reach him monthly.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

Mr. ——— was interviewed on December 12, 1959, at his residence. Mr. ——— had apparently been in bed before the interview because he was wearing pajamas and a robe. He was hard of hearing, even though he was wearing a hearing aid, but when the questions were asked slowly and at a tone slightly above normal he seemed to understand perfectly. He breathed in short gasps.

Mr. ——— said he first became aware of the disability program about 3 or 4 years ago when it was "front page stuff" in the newspapers and he had frequently thought about it until he filed his application for disability benefits. He also had a little booklet on social security which he had read many times. He could not remember for sure where he got the booklet and he has since passed it on to a friend.

He said that he only had to wait about 10 minutes in the district office before he was able to talk to someone and that he was treated "very well." They did not explain his rights under the program nor did they tell him how disabled he had to be in order to qualify. He said he got this information from the booklet. He believes he made up his own mind about whether or not to file. They did not discourage him "one bit."

Mr. ——— could not remember if the district office filled out the application for him but said that they must have done so because the questions were explained fully and plainly. To get his medical proofs, he authorized the district office to interview his doctors. He did not take any forms to any doctors or hospitals. He was not charged for the preparation of any of the forms. He had been going to his own doctor regularly and he did not have a special examination by him, but he did have an examination by a doctor provided by the State agency. No charge was made for this examination. He does not know if the district office received any reports from his doctors or the hospital.

He did not feel that he required additional assistance but he said he might have if he had been turned down. No assistance was received from any other person or organization.

The booklet contained the address of Social Security district office and he went there to file his claim. At that office, they told him his claim would be handled by another district office but they treated him very nicely and took his claim anyway, including the information necessary to get the medical proofs. They told him that he would be hearing from the other office in about 2 months. He said that it was "a bit unusual" to receive that kind of treatment in a government office and he gave examples of having difficulty with various State and city offices. He said that he had heard about red-tape that was involved and shortly before he filed his application he read about a person who had died before receiving his benefits. This, he said, had kind of discouraged him and he kind of expected to be "brushed off" when he found out that he was at the wrong district office.

He later received a letter from the other district office asking him to come in. When he went there, he did not have to wait and they treated him courteously.

He could not think of one criticism. He had to wait a while before receiving his benefits, he said, but he had expected that.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

Mr. ——— was interviewed on December 10, 1959, at his home. Mr. ——— has a pleasant personality and is neat in appearance. From his mobility, it is hard to believe that he is a heart patient.

Mr. ——— said that he learned about the disability program through his union. He said that he believes there is no finer group of people than at the ——— district office and he was treated courteously and the people were very helpful. He did not wait longer than about 2 minutes for someone to talk to him.

Mr. ——— said that the disability program and his rights under it were fully explained to him. He was not told by the district office people how old he would have to be to qualify for disability benefits. He simply stated his case to the interviewing person at the district office with the sole purpose of filing a claim.

Mr. ——— said that the person at the district office filled in the necessary forms from information supplied by him. He said that he was given medical report forms and requested to take the forms to his doctor to fill in the necessary information. His doctor examined him at that time and charged for this examination but not for the preparation of the forms. He had been going to his doctor every 2 or 3 weeks for examination. These were regular office visits and the doctor charged for them.

He said he does not know if the district office obtained reports on his case from doctors or hospitals. However, his doctor had three other doctors in a consultant capacity and he believes their reports

went to the district office with the report of his own doctor. The only assistance he had in filing his claim was from the district office. He did not feel he needed assistance from any other person or organization.

He had no other comments to make on his treatment by the district office except to say that he could not praise them highly enough.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed Mr. ——— on December 29, 1959, in his home. Mr. ———, 57 years old, lives with his wife and three daughters in a very nice suburban section. Mr. ———, a former restaurant owner, has not worked for 2 years. The beneficiary stated he is suffering from hypertension and heart trouble; however, he seemed healthy. Mr. ——— was very frank in answering my questions.

The beneficiary learned of the disability program from friends and announcements over the radio. The beneficiary stated that during all his contacts with the people in the Social Security district offices he was treated very courteously and he never waited more than 5 minutes before someone talked to him. Mr. ——— felt that the disability program and his rights under it were fully explained to him and stated that the district office representative explained that it would take some time to process his claim because the determination as to the extent of his disability would have to be made by the State agency.

Mr. ——— stated the district office representative told him it would be easier to get disability benefits if he was missing a leg or an arm or was blind; however, because he had no apparent disabling condition he would have to obtain medical evidence of his disability. He stated he felt the district office people neither encouraged nor discouraged him from filing for benefits but merely processed his application and gave him the medical report forms upon his request.

Mr. ——— stated that the district office representative filled out his application while questioning him and then he signed it. He took medical reports to two of his own doctors. Neither doctor charged him for preparation of the report; one doctor made a current examination at the time of submitting the medical report and the other doctor filled out the report from medical history on Mr. ——— in his files. Although Mr. ——— was hospitalized he does not know if the district office obtained medical reports from the hospital. He stated that he was asked by the State vocational rehabilitation agency to submit to an examination by one of two doctors and he selected a Dr. ——— because of the nearness of the doctor's office to his home. He stated that the doctor was courteous and gave him a very thorough examination.

Mr. ——— stated that at no time did he feel he needed additional assistance in preparing his claim. He stated that he felt it takes a long time before one receives benefits; however, he stated that he recognized the administrative problems in processing disability claims.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed Mr. ———, a 59-year-old disability beneficiary, in his home on December 30, 1959. Mr. ———, a printer, has not worked for 2 years. The beneficiary appears in good health and lives with his wife in a ranch-type brick home. His monthly income consists of Veterans' Administration benefits and insurance of \$124 and disability benefits of \$116. Mr. ——— was very frank and explained that he is suffering from arteriosclerosis and has no discernible pulse in the lower part of his legs.

Mr. ——— learned about the disability program from a weekly newspaper column which deals with social security benefits. He stated he knew the location of the local district office. Mr. ——— had been denied benefits after his initial application and subsequently requested a reconsideration of his case. He stated that he had been treated very courteously on all occasions by the people in the district office. Mr. ——— never waited more than an hour before someone talked to him in the district office; he stated that he had no criticisms because he has waited a lot longer in some doctors' offices. He felt the disability program and his rights under it were fully explained to him and stated that on his initial visit, he was given pamphlets and told to return after waiting 6 months. He stated that the district office people neither encouraged nor discouraged him from filing an application; they told him that the determination as to whether or not he was totally and permanently disabled would not be made by them. Mr. ——— stated that the Social Security representative filled out his application and he signed it. In addition, he was given medical report forms to have filled out by his doctors. He stated he took the medical report forms to two doctors and that neither doctor charged for its preparation. One doctor who had performed surgery on Mr. ——— merely submitted the information concerning the operation; his regular doctor examined Mr. ——— during his regular monthly checkup prior to submitting the medical report form. In addition, he stated that medical report forms were submitted on his behalf by the hospital where he had undergone treatment.

Mr. ——— stated that at no time did he feel he needed additional assistance in preparing his claim; however, he stated that he wrote to the Baltimore office questioning the delay in the processing of his claim and asking if all the medical evidence had been submitted. Mr. ——— stated that it took 14 months for his social security disability claim to be processed but it took less than 2 months for his insurance claim, on a company policy providing for full payment in the event of disability, to be processed.

Mr. ——— requested reconsideration of his case after he received a denial letter because his doctors told him he would be unable to return to work. He criticized the denial letter stating it was a form letter telling him he was able to work to some extent but not detailing what type of work he could do. Mr. ——— stated that the district office had a copy of the denial letter he received and they explained his right to reconsideration.

Mr. ——— stated that he was requested to submit to two medical examinations. When he learned that one of the doctors was a psychiatrist he stated he was about to give up but decided to go to the district office and ask them why he had to go to a psychiatrist. He stated that they explained that his type of disability can lead to forgetfulness and that it would be necessary for him to submit to a psychiatric examination. Mr. ——— said that the two doctors, the other one being a heart specialist, were very courteous and the "best in town." He stated that the heart specialist gave him a very thorough examination, "almost as thorough as those performed at the hospital."

I thank him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed Mr. ——— on January 6, 1960, at his home. He is 56 years of age, has asthma and a heart condition, and has been unable to work for the past 2½ years. Mr. ——— said he worked for a company for 19 years on a delivery truck, after which he operated a night club of his own for 2 years but sold out in 1953. After that he tried working as a cook and also selling feed. The exertion was too much and under doctor's advice he stopped work altogether in 1957. He lives with his brother-in-law and wife in a poor section of the town.

Mr. ——— stated he had found out about the social security disability program from the local newspapers, and filed the claim at the post office, where a Social Security representative comes each Monday.

He stated he waited about 4 hours on his first call to see the Social Security representative but was treated courteously when his turn finally came. He said he thought that his rights under the disability program were explained to him and he was told the basis for approval of his claim would be his inability to work because of physical ailments. The Social Security representative encouraged him to file. He stated that the Social Security representative asked questions and wrote the answers on a form, which he signed without reviewing.

The Social Security representative sent a medical report form to a doctor and requested Mr. ——— to go there for a physical examination.

The Social Security Office also secured medical evidence for him from two other doctors. There were no charges either for filling out the reports or for making the examination.

The applicant received his first check in September 1959, which included payment for 7 months of 1958 and the first 8 months of 1959.

Mr. ——— stated he has no other income or assets.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed Miss ——— on January 5, 1960, at her residence. She was 61 years old December 28, 1959. She has a heart ailment which has bothered her for quite some time.

Miss ——— stated that while hospitalized, a neighbor asked her if she knew of the disability program. She made further inquiry and

stated the Social Security representative came to the local hospital, in April 1959, to assist her in filing the application.

The applicant said the Social Security representative filled out the form and explained the program in a general way but did not go into the extent of disability necessary to qualify and did not explain anything about rights or procedures in case of denial. He apparently encouraged her to file by not discouraging it, and she thought she had given him sufficient data for her claim to be allowed.

The Social Security representative mailed the medical report blanks to the applicant in the hospital and she gave them to the doctor and the hospital to send them in. She was not charged for preparation of the reports and if any physical examination was charged for, it was prior to making out the application and in connection with the heart attack. She mailed no report forms to other doctors, institutions, or hospitals, and had no knowledge of anyone else doing so.

She stated that she had not felt the need of additional assistance after talking to the Social Security representative. She did not obtain help from any other source and had no other comment on her treatment by the Social Security representative except that she was so thankful her claim had been approved as she would not have known what to do next had it been denied.

Miss ——— stated she received her first check in October 1959 which was for the prior 3 months. She stated she is unable to work and has no other source of income.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

On December 14, 1959, this beneficiary was interviewed in his small apartment. He appeared to be healthy and mentally alert. He answered all questions readily.

Mr. ——— said that he learned of the social security disability program through the State unemployment office. He said he was treated courteously by the people in the Social Security district office, that he did not have to wait long before talking to someone, and that the disability program and his rights under it were fully explained to him. The district office representative described to him verbally how disabled he would have to be to qualify for benefits and encouraged him to file an application.

The district office also gave him medical report forms which he took to his doctor. Subsequently, Mr. ——— was hospitalized. His wife received an additional medical report form at home and took it to the hospital for completion. Mr. ——— received sufficient help in filing his application.

Mr. ——— was not charged for the preparation of the medical report and his doctor did not examine him at that time. The applicant is unemployed.

I thanked him for his cooperation.

DISABILITY SURVEY REPORT

INTERVIEW REPORT

Applicant Receiving Benefits

I kept an appointment with Mr. ——— on January 4, 1960. He is age 52, lives with his wife and is being paid \$110 a month social security disability benefit. He owns his home. His wife is regularly employed. Mr. ——— has a healthy outward appearance. He can use both his arms and can walk about without apparent difficulty. He answered our questions readily and completely. He complained about what he called "absent mindedness" and he attributed this to the large amount of tranquilizers which he has been taking as prescribed.

The beneficiary said that he first found out about the disability program from a friend of his, who suggested to him that he try to get disability benefits if he was covered by social security. Mr. ——— knew where the district office was located.

The beneficiary said that on his first and only call at the district office he received prompt attention, was treated courteously, and was given all the information and explanation he believed was needed. He said that the representative asked him a number of questions and then filled out the application and other papers.

The beneficiary said that the district office mailed him medical forms and instructions concerning required medical evidence. He stated that he went first to his own family physician who had been treating him for 2 years or more. She filled in the form, examined him, and charged him for an office visit. He said that his doctor told him to take a medical form to the State psychiatric hospital. The beneficiary said that at this hospital he was thoroughly examined by two doctors. He said that he paid a medical fee of \$1 at this hospital.

After he first talked to the Social Security district office, Mr. ——— said he felt no need of any further assistance in preparing his claim. The beneficiary stated that he has neither asked for nor received any help from any outside source in presenting his claim.

The beneficiary said that the Social Security district office had given him "very fine and satisfactory treatment" and that he had "no argument or tough time at all."

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I was able to meet Mr. ——— and his wife on December 14, 1959, at their home. Their house is a clean little summer type cottage on the banks of a small river. The house gives the impression it would be a summer paradise; however, Mr. ——— doctors strongly advised him to move to a drier climate. They maintain the dampness doesn't help his lung cancer. Because of the roots Mr. ——— has established in this community and because of his financial shortcomings he has been unable to heed his doctor's advice.

Mr. ——— first became aware of the disability program through the union of which he was a member at his work. One of the union representatives instructed him where to find the district office and

Mr. ——— accompanied by his wife went there. He found all persons at the district office he talked to, either by phone or in person, most courteous and eager to help in any way they could.

The applicant stated that when he and his wife visited the district office they were taken care of promptly after waiting only a few minutes. At that time Mr. ——— rights were carefully explained to him and his wife so they both understood them. They were told that an applicant must be incapable of carrying on any substantial gainful activity before he could be entitled to disability benefits. Mrs. ——— assured me her husband was neither encouraged or discouraged from filing. They decided themselves to file.

It wasn't necessary for the district office to give much assistance in this case since Mr. ——— had the advantage of at least a high school education. He was given an application and asked to fill it out. At the time he was told not to hesitate to ask if any of the questions were not clear. He was given a medical report form and asked to have it completed by his doctor. His doctor gave him a current examination before completing the report and charged him the regular fee. Social Security sent him to another doctor for an examination but he was not charged for this examination. Mr. ——— assumes Social Security obtained other medical information because he gave them permission to do so.

Mr. ——— had no adverse criticism of the Social Security program. He receives his check monthly and feels the program is a "God send." Mr. ——— tried to return to work shortly after his first operation but was unable to continue. His doctor told him he was cutting his remaining years in half by trying to work.

I thanked them for their cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I called on Mr. ——— at his home. Mr. ——— impressed me as being a very healthy robust individual many years younger than his actual 59 years.

Mr. ——— stated he first learned about the disability program through the local newspaper. The applicant made three trips to the local district office. He claimed that someone from Social Security was watching his house from an automobile parked across the street on three different occasions. His neighbor first called this to his attention and Mr. ——— wanted to bring the neighbor in to verify his story, but I told him it wouldn't be necessary.

Mr. ——— was very emphatic in his criticism of the district office people. He stated on each of his three visits he had to wait more than one-half hour before being asked if he could be helped. He did not believe this to be reasonable since on each trip there was no one before him. Mr. ——— explained the district office people laughed and joked together while he waited. The applicant stated that the employees were certainly not courteous, and in fact, on his first visit he thought the lady most discourteous as she snapped questions at him and became irritated when he did not understand some of them without repeating. According to the claimant's statements little was ex-

plained to him about the disability program, his rights or anything else, and the only way he was able to piece together any knowledge was by asking countless questions and reading a small booklet which he found on one of the tables there. On one occasion when making an inquiry by phone, the applicant was told that if he could go out of the house alone, or even watch his model railroad he could be declared ineligible.

Mr. ——— was actually discouraged from filing an application on his first visit to the district office. He was told to come back in several months and then file. The applicant was aware of the fact that you must be disabled for 6 months before being eligible for benefits and this being the law nothing could be done, so he had no objections. He did object, however, that Social Security would not accept his application at an earlier date. Had they done so checks would have started to arrive at the end of 6 months rather than 9 months as it turned out. Before the receipt of his first check, Mr. ——— wrote to his Senator to find out the cause of the delay in his receiving a check. In this letter the applicant criticized the social security program harshly and said "a shake-up from the top down was needed."

During our interview Mr. ——— told me he received all the help he needed in filling out the application. The Social Security representative asked questions and inserted the answers on the application. He was given a medical report form which he took to his family doctor. The doctor completed the form without charge to the patient. Mr. ——— stated he was not examined at this time, possibly, because he had been a regular patient for years and had been in the doctor's office only a few days before giving him the medical report. Mr. ——— explained Social Security contacted a hospital, Veterans' Administration, and an insurance company to obtain additional medical information. The applicant was sent to see two other doctors which Social Security designated, one a psychiatrist. Neither doctor charged the applicant for the examination.

Mr. ——— believes he could have filled out the application without the assistance he was given and likewise obtained the medical information needed.

When I asked the applicant if he had any other comments on his treatment by the district office, he very methodically enumerated the following:

1. No parking facilities at the district office, therefore forced to drive around block many times.
2. Objected to waiting one-half hour even though first in line.
3. Disliked being waited on by female Social Security representative.
4. Thought Social Security representatives very discourteous.
5. Could not understand why Social Security would not accept his application on his first visit but made him return 3 months later to file.
6. Thought many of the questions asked by the Social Security representative were too personal and irrelevant as to whether a disability existed.
7. Resented having Social Security send him to their doctors rather than just relying on his family doctor's report.

8. Felt very indignant that Social Security representative was watching his house.

9. Disliked calling the Social Security office and not being able to get a straight answer.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

Mr. ——— was interviewed on December 11, 1959, at his residence. Mr. ——— is a rather frail person and he appears quite unable to freely navigate. He said he is 63 years old and has not worked since October 1, 1957. He seemed intelligent and took time to think about the questions before answering them. His wife was present during the interview.

Mr. ——— said he read about the disability program in the local newspapers and heard about it from neighbors and friends. He said he was treated very well by the Social Security district office. He did not have to wait as he was immediately introduced to a claims representative and the disability program was fully explained to him as well as his rights under the program. He was treated very courteously.

Mr. ——— could not recollect at this time whether or not the claims representative talked about how disabled he had to be to qualify for disability benefits. He said that the claims representative told him that under his present disabled condition he should file a claim for disability benefits and that the Baltimore office of Social Security would adjudicate his claim.

Mr. ——— said that the claims representative filled in the necessary application forms from information provided by him. He signed all the forms as best he could. The district office sent medical report forms to his family doctor and to a chiropractor. He was not charged for the preparation of these medical report forms. On receipt of the medical report form, his family doctor called him to his office for an examination. He was not charged for this examination. He did not take or mail medical report forms to other doctors. He has no way of knowing if the district office received the medical reports from his family doctor, the chiropractor or other doctors.

Mr. ——— said he had sufficient assistance in preparing his claim at the district office and felt he did not need other assistance. He had no other comments on his treatment at the district office except to say he received good treatment and he is satisfied.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I met with this 58-year-old beneficiary on December 23, 1959. Mr. ——— lives alone in an attic apartment above his son's residence and relies solely on his disability benefits and assistance from his son. The beneficiary appeared healthy, but stated that he is suffering from a coronary condition and one of the arteries to his heart is slowly closing. Mr. ——— stated he worked for one company for 39 years as

a maintenance machinist prior to quitting because of his disability early in 1957.

Mr. ——— learned of the social security disability program from fellow employees and also by listening to television announcements. He visited the Social Security district office after learning of its location from friends who were receiving benefits.

Mr. ——— stated that he was treated very courteously at all times by the Social Security district office people; however, on one occasion he was required to take a number and wait for about an hour before someone talked to him. He stated that the district office representative spent over an hour in processing his claim and explaining the disability program and his rights under it; however, he stated that although he sought information as to how disabled he had to be to qualify, the district office representative did not give him any information in this regard stating that only a doctor is qualified to make such a determination. Mr. ——— feels that the district office representative merely processed his application without attempting to encourage or discourage him from filing.

Mr. ——— stated that a secretary filled out his application while he was questioned by the district office representative who presented the application to him for his signature. The beneficiary could not recall receiving any medical report forms from the district office but stated that two hospitals furnished medical proof of his disability. The beneficiary stated that he trusted Social Security officials and at no time did he feel he needed any additional assistance in preparing his claim.

Mr. ——— stated he went to the district office to request a hearing even though he understood the reason why his claim was denied, because he disagreed with the decision and felt he was entitled to benefits. Mr. ——— requested a hearing without asking or being told by the district office representative the reason why his claim was denied. He said that the district office employee merely told him they would notify him of the time of the hearing. The beneficiary stated that he was not informed that he could submit additional medical evidence on his case and the district office representative did not in any way express an opinion as to whether or not his case should be appealed to a referee.

Mr. ——— cannot recall being told that he had a choice of having a hearing in person before a referee or having the referee decide his case from the papers that were in the record. He believes he was told he had to appear in person.

After receiving a very thorough examination by a doctor selected by the State agency, Mr. ——— was notified that he was entitled to benefits. Mr. ——— feels that independent medical examinations should be given to all disability applicants to eliminate applicants who have received biased reports from their regular doctor.

The beneficiary stated that he currently spends about \$36 a month on medicine and spent his life savings of \$12,000 on surgery for his wife who died several years ago. He believes the social security program should provide some relief for aged or disabled persons who cannot afford the cost of medical treatment. He believes that a hospitalization plan and increased benefits could be provided by eliminating the current ceiling of \$4,800 on which social security taxes are collected.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

Mr. ——— is 55 years old, worked 23 years for a railroad, leaving there in July 1943 to work for another company until he suffered a stroke. He receives a railroad pension of \$95 per month. He filed his application for disability benefits in May 1959, and received checks in October 1959 for the months of August and September 1959.

Mr. ——— said that he heard of the disability program from conversation with friends. A representative from the local office came to his residence about 6 weeks after his visit to the office to file the application. He stated he was treated "OK" by the Social Security representatives and did not wait long on original visit. He said that the man at the office was rather curt; he just asked the questions and wrote in the answers. The lady who called at his home was much more explanatory and helpful but neither went into the extent of disability necessary to qualify. No one encouraged or discouraged him as to filing; they just filled out forms and told him someone would call and advise him as to results.

The Social Security representative filled out the required application form and mailed the medical report form to his doctor, who returned it completed without charge to the applicant. The report was based on the doctor's records, which dated back to February 1959, when Mr. ——— suffered the stroke, and has since been unable to work.

Mr. ——— had no other comments about the social security laws or representatives.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed Mr. ——— in his home on December 22, 1959. He lives in a bungalow near the edge of the city limits. He will be 63 years of age in February 1960 and draws a disability pension of \$66 a month as a World War I veteran. He filed his application in April 1959 and received allowance in October 1959. He also has a company pension of \$67 a month.

Mr. ——— found out about the program through the press, and a neighbor told him where he could apply. No representative of Social Security came to see him at home. He said he was treated "OK" by the Social Security people and did not have to wait long at the Social Security office. He did not recall receiving any explanation as to how disabled he had to be to qualify but said they did encourage him to file and reminded him "he had nothing to lose."

The Social Security employee filled out the application in response to the applicant's answers. He took the medical report to his doctor, who had just made a physical examination the prior week. The doctor did not charge for preparation of the medical report. He said the State rehabilitation agency sent him to another doctor for an examination about 3 months after his filing. He stated he filed the application as suggested by the Social Security office and did not feel he needed further assistance. He had no other comments except to say they were very cooperative at the Social Security office.

Mr. ——— suggested that there should be a provision for sick and health benefits and medicine to those requiring it.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I called on Mr. ——— at his home on December 15, 1959. The applicant impressed me as being very sincere and distressed at the fact that he was forced to stay at home rather than return to his job in an iron foundry. The applicant apologized because he was compelled to sit through the interview in his undershirt with all the windows open, even though the temperature outside was in the thirties. He claimed this the only way he could get any relief when his high blood pressure acted up.

Mr. ——— learned of the disability program through his job and believes the local post office employees gave him directions where to apply for benefits. The applicant did not actually go to the district office which normally covers the area, but met a Social Security representative at another place.

Mr. ——— stated he was treated very courteously by the Social Security representative and at most waited only a half an hour before being waited on. He informed me that the disability program was fully explained to him and his rights under the program were defined. The Social Security employee stated a disability had to be sufficiently severe to prevent the person from doing any substantial work. Mr. ——— asserted that the decision to file or not was his own and no influence was asserted in one way or another.

The applicant emphasized that he had little to do on his own in preparing his case. The district office representative filled in the application. Mr. ——— stated he asked him questions and wrote the answers on the application. It seemed to take less than 20 minutes to complete the entire process. The applicant was then instructed to take a medical report form to both his family doctor and an eye specialist. Both doctors gave him an examination before completing the medical report, but neither one charged him. Mr. ——— was sent to another city by Social Security and there examined by a third doctor. This doctor told the claimant he would advise Social Security of the results of this examination.

Mr. ——— was very pleased at his treatment by all representatives of Social Security and had no complaints. He stated he would certainly like to return to work, in fact, he had actually tried but after 1 week had to give it up.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

Mrs. ——— was interviewed on December 10, 1959 at her residence. At the time of the interview, Mrs. ——— was tending one of her grandsons. She was a little frightened at first but after it was explained how her name was selected and after the first few questions were asked, she was calm and very cooperative.

Mrs. ——— said that she found out about the disability program by being referred to the Social Security district office by the State unemployment office. She was accompanied by her nephew when she went to the district office. At the district office she was treated "very nice" and did not have any complaints; in fact, she was able to speak to them right away. They explained the program to her in what she called "simple words" but she could not recall if they told her how disabled she had to be. They said they couldn't tell her anything for sure until they received her medical records. She said she filed her application because she wanted to and that they did not discourage her.

Mrs. ——— said that the district office representative filled out the application while he read it to her and explained its contents in plain words. She signed two forms giving permission for the district office to get her medical proofs, and she took one to her doctor and one to the hospital. She had often been going to her doctor and guessed that he knew enough about her to fill out the forms. She did not have a special examination. She was not charged for the preparation of the forms or for any other service she received.

Mrs. ——— said that other than the referral by the State unemployment office, she was not assisted by any other person or organization. She did not feel that she needed further assistance.

She said she didn't have any complaints at all and that the district office was "very, very nice with me." She thinks they treat people very "decently." Shortly after she had filed for her benefits, she said she got a little worried because her regular mailman was replaced and called the district office. They replied to her in the form of a letter which she said was very nice. It explained to her that she would receive benefits but that it would be a while before they would start.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed this 63-year-old applicant on January 5, 1960. Mrs. ——— lives with her husband in a nice 5-room apartment. Her husband was present during the interview but did not attempt to influence his wife during the interview. The applicant, while brief and sincere in her comments relating to the questions asked during the interview, talked at length about her disability.

Mrs. ——— was not aware of the Social Security disability program until her first visit to the district office. She had gone there because she believed that she was required to report to Social Security the fact that she was unable to work. The location of the district office was previously known to the applicant. On her visits to the district office Mrs. ——— never waited more than 20 minutes before a representative talked to her and she stated that she was always treated courteously. She believes that the disability program and her rights under it were fully explained to her but that the extent of disability necessary to qualify for benefits was never explained by district office representatives. Her decision to file an application for disability benefits was not influenced by personnel at the district

office. The assistance given to Mrs. ——— in preparing her case consisted of filling out the application from information supplied by her and instructing her about furnishing medical proofs. The applicant took the medical report form to her family doctor who completed it without giving a medical examination, as she was currently under his care. The doctor did not charge for the preparation of the report. She also mailed a medical report form to another doctor.

Before making a disability determination, the State Vocational Rehabilitation Agency sent Mrs. ——— to Dr. ——— for a physical examination. The applicant thought that the examination given by this doctor was quite thorough.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant receiving benefits

I interviewed Mr. ——— at at his residence on December 28, 1959. He was 65 years old in November 1959, and lives with his wife. He has not worked since November 1957, when he had to quit a city job as street cleaner and janitor. He has received welfare assistance up to the time his social security disability was allowed. He filed his social security application in April 1959 and it was allowed in November 1959.

Mr. ——— learned of the social security disability program at the local Post Office, where he went to file his application. A representative from the district office, comes to the contact station on each Tuesday. He waited about 2 hours before seeing anyone in the Social Security office but said they were very nice to him and explained his rights under the program. He did not recall their description of the extent of disability necessary to qualify but said that they did encourage him to file.

The Social Security representative prepared the application for him. He obtained medical proofs from two doctors. He said Dr. ——— charged him for the examination, and the State welfare paid the other doctor. He was later sent to Dr. ———, by the State vocational rehabilitation agency, at no cost to him. He said he did not feel that he needed any information other than that furnished by the district office and made no effort to get any. He stated the representative was very nice to him. He added that he is appreciative of the way his case was handled by the Social Security office.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant receiving benefits

I interviewed Mr. ——— at his home. He has a heart condition and has been allowed a disability benefit by Social Security.

His doctor told him about the disability program. A Social Security representative called at his home and explained the disability program to him. He was treated courteously and his rights were explained to his satisfaction. The field representative of Social Security explained that to qualify he had to be so disabled that he couldn't work for a living. He was encouraged to file an application.

The field representative filled out his application for him and filled in a portion of the medical reports and gave him envelopes to mail the forms to the doctors and the hospital. The doctors and hospital did not charge him for preparing the medical proofs. His regular doctor did not examine him at this time but the specialist did and charged him \$15. The hospital did not examine him before completing their portion of the medical proofs.

Mr. ——— is very satisfied with the way Social Security handled his application and did not think that additional assistance was necessary to complete the application. He stated that Social Security people have been wonderful to him and he has been treated as nice as can be.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

Mr. ——— was interviewed on December 15, 1959 at his home. Mr. ——— said he is 57 years old and married. His wife was present during the entire interview. He said that the first time he went to the district office he was told that his wife might also be entitled to benefits; so he later went back with his wife. She filed her claim for a wife's benefit at that time and she is now receiving it.

Mr. ——— said he found out about the program from his family doctor and from his company. He knew where the district office was because he lived close to it. He said that the people in the district office seemed to be very efficient and knew exactly what they were talking about. He did not wait over 10 minutes the first time he went to the district office and not over 3 minutes the second time.

His rights under the program were explained to him. He said this when he found out that his wife might be eligible for benefits. In order for him to qualify the district office made it clear that he had to be unable to do any kind of work. They were "neutral" about whether or not he should file his claim.

Mr. ——— said the district office filled out the application for him, explained everything explicitly and thoroughly and he then read the application and signed it. He obtained his medical proofs from his doctors. He took the forms to two doctors and was not charged for their preparation. He did not have a special examination by either of these doctors. He was later sent to be examined by another doctor. He was not charged for this examination and he said the doctor had all the forms.

After his first visit to the district office he said he did not feel that he needed additional assistance; therefore, he did not call on any other person or organization to help him with his claim.

He said in his honest opinion he could not find one fault and that the people in the district offices were well trained and had wonderful personalities so they did not "abase" him. He had on occasions been to the State Employment office and he said there was no comparison in the way he was treated, meaning that he had been treated well at the Social Security district offices.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed this applicant on December 29, 1959. The applicant lives with his family in an old frame house. He is a carpenter but has been unemployed for 2 years. His replies to the questions seemed frank and sincere.

Mr. ——— learned of the social security disability program from weekly articles appearing in a Sunday newspaper. On his visits to the Social Security representative he never had to wait to see him as he always came early. Mr. ——— stated that the Social Security representative was always courteous to him. The representative never explained the disability requirements to the applicant but furnished him with a booklet that explained the program. The Social Security representative helped Mr. ——— to fill out the application and told him what medical evidence to secure. The applicant took the medical report form to his family physician who prepared the report without giving a physical examination since the applicant was currently under the doctor's care. Mr. ——— stated that he was not charged for the preparation of the report. He also sent a medical report form to the hospital where he had undergone examinations and treatment.

The State vocational rehabilitation agency sent the applicant to Dr. ——— for a physical examination prior to making the disability determination.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed Mr. ——— on December 17, 1959, at the home of his daughter. He stated he had not been able to work for several years, although he is only 53 years old. He has no income other than his social security disability payments. He filed his application in April 1959 and received notice of allowance and first check in October 1959.

Mr. ——— heard of the program while a patient in the hospital. He looked up the address of the district office and went there to file

his application. He waited about 45 minutes to talk to a Social Security representative and was treated very courteously. He was given pamphlets, the program was explained, and he was told that he could not qualify if he was able to perform any kind of work. No one encouraged him to file and he made up his own mind.

Mr. ——— said that the Social Security representative wrote in his answers on the application form. He took the medical report forms to his doctor, and to the hospital. He was not charged for their preparation. He did not have a complete physical examination at this time, as he had been out of the hospital only 2 weeks. Other medical report forms were mailed to three other doctors and a hospital. He said the State rehabilitation agency sent him to another doctor for an examination. He did not feel he needed any additional assistance in preparation of his claim after his visit to the district office. His only other comment was to stress that all Social Security personnel were courteous to him.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed this 63-year-old beneficiary at his residence on December 14, 1959. He lives with his aged mother and his widowed sister in a neat six-room row home. Mr. ———'s general appearance indicated that he is not in good health. He was thin and short-winded. He spoke slowly and had trouble breathing.

Mr. ——— stated that he learned about the social security disability program from his newspaper. In June 1959, he went to the Social Security office. He waited 15 to 30 minutes before he was referred to a Social Security representative. Mr. ——— thought the representative was very courteous and helpful. He did not believe that the disability program was adequately explained to him nor was he told how disabled he had to be. The Social Security representative assisted Mr. ——— in completing the applications and gave him two medical report forms for his doctors.

His physician charged him \$5 for a current medical examination including the preparation of the medical report. Another doctor charged him \$4 for a current medical examination including the preparation of the medical report. Mr. ——— mailed the two completed medical forms to the district office.

The State rehabilitation agency, prior to making the disability determination, sent Mr. ——— to a hospital for a complete medical examination. Mr. ——— stated that he was treated very courteously at the hospital during the various examinations and tests.

Mr. ——— stated that he was called to the district office a second time to answer some questions and have some additional papers completed. This time the office was very crowded and he had to wait about 1 hour before the Social Security representative could see him. He

stated that everyone he met at the Social Security office was very courteous to him. Mr. ——— is not presently working.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I kept an appointment with Mr. ——— on January 6, 1960. The beneficiary appears to be almost totally blind. He told me that he has an artificial right eye and that he is now faced with an operation on his left eye. He said that the doctors informed him that he has a 50-50 chance of preserving even a slight amount of vision in his left eye. Mr. ——— is 60 years old. He is not able to get about outside his own premises without his wife's help. She has to drive their car on any trip they take. The ——— family receives two checks each month from Social Security which amount to \$210, because Mrs. ——— has a 17-year-old son of the wage earner in her care. Mr. ——— was able to answer any questions I asked him. His wife was present at the interview. They said that his eye disease had been diagnosed as cataracts and glaucoma.

Financially, the beneficiary appears to be very comfortably fixed. They told me that they own a large plot of ground which they lease to a restaurant and a diner next to their home. They operate a motel at the same site occupied by their residence. Mr. ——— formerly owned the diner but sold it in 1947.

Mr. ——— said that he first learned about the social security program from an accountant whom he has employed for many years. The accountant kept the books for the diner and now handles all of their accounting and tax affairs.

Mr. ———, accompanied by his wife, made only one trip to the district office and the district manager interviewed them. Mr. ——— said that he described to the district office the experience he had with his eye disease.

Both Mr. and Mrs. ——— said that the district manager gave them the impression that the probability was rather good that Mr. ——— could qualify for disability benefits. They said that they had received courteous and prompt attention, had been given a full explanation of his rights under the program, and had been informed as to the required degree of disability necessary to qualify.

Mr. ——— said that he was given a number of medical forms which he was requested to take or mail to the various doctors and hospitals having medical information about him. The beneficiary said that he mailed the forms and thereafter did not have to take any specific examinations for social security. He said that he had received one or more visits from a State rehabilitation representative.

Mr. ——— said that he had been covered by social security since 1951 as a self-employed individual and that he had always reported the maximum earnings applicable to the various years.

During the interview, both Mr. ——— and his wife freely and frankly volunteered information about his ability to function effi-

ciently in every major phase of their motel business. He is so thoroughly familiar with the physical layout that he can answer the telephone, talk to prospective room renters, show them to their room location, and transact any phase of administrative business. He is not able to read papers such as bills, receipts, count money, and make change. If any of these acts are necessary, he has his wife to help him.

I thanked them for their cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed this 60-year-old beneficiary in her home on December 29, 1959. Approximately 20 minutes prior to calling on Mrs. ——— I interviewed her physician, Dr. ———, who informed me that she had a slight stroke on December 25. He said that he had visited her a few hours before our interview and that he found her to be making a slow recovery. I told him of my appointment with Mrs. ——— and he gave me his approval for the visit.

Mrs. ——— lives in a brick house with her husband and unmarried daughter, both of whom work. Mrs. ———, who remained seated during the entire interview, was very pale and appeared tired and nervous. Her daughter gave me all the information and consulted her mother only when necessary. Mrs. ——— did very little talking. Her claim was allowed in September 1959 approximately 3 months after she filed her application. She receives \$98 a month.

The personnel manager for the company she worked for advised her to apply for disability pension and told her where to apply. Her daughter took her to the district office, sometime in May or June 1959. They did not have to wait long and they were treated courteously. Miss ——— stated that they were given a booklet on the disability program but that the claims representative did not explain the program and her rights under it. Miss ——— did say that the representative gave them a brief description of how disabled an applicant must be to qualify. They were neither encouraged nor discouraged to file an application.

The representative completed the application for Mrs. ——— based on the information that she and her daughter gave him. They were given a copy of the medical report which she took to her doctor. Mrs. ——— was not given an examination at that time and did not pay for the preparation of the report. Miss ——— explained that the doctor also submitted a cardiogram which had been taken sometime earlier at his request. Shortly after filing her application Mrs. ——— was notified by the State rehabilitation agency to go to a heart specialist for an examination. They did not feel that they needed additional assistance in preparing the claim and did not receive any assistance from other persons or organizations. Miss ——— emphasized that her mother was well pleased with the manner in which her claim was handled. Mrs. ——— nodded her head in concurrence with her daughter's statement.

I thanked them for their cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

Mr. ——— was interviewed on December 23, 1959, at his home. Mr. ——— said he is 62 years old, married, and has not worked since February 24, 1959. He said he had suffered a heart attack in 1949 and a second one on February 24, 1959, and has been under doctors' care since that date. He said he now visits his family doctor every 2 weeks. He appeared well but said he could not do any hard work. Even going up and down stairs tires him. His wife was present during the interview.

Mr. ——— said he learned about the social security disability program from fellow employees. He said that when he visited the district office he only waited about 5 or 10 minutes before someone talked to him and he was treated very courteously. He was given booklets to read and the disability program was explained to him. He was told he would have to be home for 6 months and be totally disabled before he could qualify for social security disability benefits. He was encouraged to file a disability claim because he was home, ill, and disabled.

Mr. ——— said the district office people filled in disability application forms from information he gave them. He signed the forms. He said the district office representative gave him a medical report form to take to his doctor. He was not charged for the preparation of the form. He said Dr. ——— did examine him at this time. He was not charged for the examination because he goes to his doctor every 2 weeks. Mr. ——— said he did not take or mail a medical report form to other doctors.

Mr. ——— feels that he had sufficient assistance at the district office in preparing his disability claim. He did not have help from any other person or organization.

He had no other comments on his treatment by the district office people, except to say they were very nice and helped him.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed the applicant on December 21, 1959. Mr. ——— lives with his son and daughter-in-law in a modest home. The applicant has been unemployed since 1952. Mr. ——— has a little difficulty with the English language. For that reason his son was present during the interview. However, it was not necessary for him to assist in obtaining answers as Mr. ——— was able to understand and answer all of the questions asked.

Mr. ——— learned of the social security disability program from reading newspapers and knew the location of the nearest Social Security district office prior to filing for disability benefits. The appli-

cant waited for 10 to 15 minutes before a Social Security representative saw him. Mr. ——— stated that the representatives were always courteous and helpful. The only assistance rendered the applicant was filling out the application. The applicant was not given any information about the disability program and he was not told in a manner he could understand how disabled he had to be to qualify for benefits. Mr. ——— took the medical report forms to his doctor who gave him a physical examination. The doctor did not charge him for preparing the medical proof but did charge for the examination. Mr. ——— was not required to obtain additional medical proofs.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed Mr. ——— in his home on January 4, 1960. Mr. ——— and his wife live in a comparatively new and modern one-story house. Mr. ——— stated he is 63½ years of age and that he retired in July 1958. He first filed an application for social security disability in January 1959, which was denied in July 1959. He subsequently asked for reconsideration and in October 1959 his case was approved and he received payments for January through October 1959 at that time. He receives \$192 monthly in retirement benefits from his company.

Mr. ——— knew of the disability program and was aware of the location of the district office. He went there to file his application. No Social Security representative called at his home. He waited about 15 minutes at the Social Security office and said he was treated courteously. The woman employee was efficient and capable, fully explained his rights under the program, explained that he must be totally disabled to qualify, and did not attempt to encourage or discourage him to file an application.

Mr. ——— said the lady helped fill in the application form and gave him the medical report form to take to his physician. He said that he was examined by the doctor but was not sure whether or not he was charged for the examination. He did not feel he needed any assistance other than that given by the Social Security office and did not obtain any. He said the district office gave him excellent service. He also said he is not working, his only income is as stated, and his doctor advised him not to work.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed Mrs. ——— on January 4, 1960, in her home. She lives in a bungalow in a middle-class section of the city with a housekeeper. She was 64 years of age in June 1959 when she filed applica-

tion for social security disability benefits. She said that in addition to heart trouble and arthritis, she now has high blood pressure. Her claim was allowed in August 1959, and she received payment in October for the months of June through October.

Mrs. ——— found out about the program through her daughter who made inquiry at the district office. Mrs. ——— did not go to the Social Security office. The latter gave the daughter a card to be filled out and returned by the mother, after which a Social Security office representative came to the house and assisted Mrs. ——— in preparing her application. She said she was treated very courteously, and the program and her rights were fully explained to her. She stated that in answer to her question as to the extent of disability to qualify for benefits the Social Security representative said he didn't know. She stated no one influenced her to file or not to file.

The Social Security representative helped to fill in the application form and gave Mrs. ——— a medical report form which she took to her physician. The same doctor had been treating her for 2 years and did not give her a physical examination. He did not charge for preparation of the medical report. She did not know of any other reports obtained by the district office. She did not feel the need of any additional assistance after talking to the Social Security representative and did not solicit any. She had no additional comment except to repeat the Social Security representative was very nice.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

Mrs. ——— was interviewed on December 15, 1959, at her residence. Mrs. ——— said she is 59 years old and married but is not living with her husband. She lives with her daughter who was present during part of the interview.

Mrs. ——— said she found out about the disability program as a result of a speech that her daughter heard at the county hospital. The speech was given by a Social Security representative at the time the hospital employees were trying to get coverage under social security. Her daughter told her about the speech and they went to the Social Security district office together.

Mrs. ——— said that she didn't have to wait long at the district office, stating further, "I couldn't be treated any better; they were very nice." She said that the district office people mainly asked her questions but did explain to her that she had to be so disabled that she could not work and gave her a card to send in if her doctor ever released her to go to work. They didn't discourage her from filing her claim but they did tell her that if she was going to file to do it as soon as possible because it takes a long time.

Mrs. ——— said that she only went to the district office once, sent in her birth certificate, and took forms to her doctors. Other

than that the district office did everything for her. They filled out the application for her and explained each question.

She said that to get her medical proofs she took a form to each of three doctors that had been treating her. They did not charge her for preparing the forms but she was charged for an examination that was given by her "arthritis doctor." He took X-rays of the ankles, knees, and hands, and also gave her a vital capacity test. This examination was given after she had filed for benefits.

The district office did not receive any other reports, she said, and she was sure they received the reports from the doctors to whom she had taken the forms. She said the district office called her twice and told her that everything was "ready to be sent in" as soon as they got them. Apparently, there was a little delay on the part of the doctors.

She did not feel that she needed additional assistance after her visit nor did any other person or organization assist her in filing her claim.

The district office people told her that if she needed any additional assistance that she should not hesitate calling them.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed this 52-year-old beneficiary at his residence on December 14, 1959. He lives with his wife and three children in a five-room apartment in a housing project. The beneficiary was emaciated and looked much older than 52 years of age.

Mr. ——— stated that he was hospitalized for about 6½ weeks and released in November 1958. After this he went to the hospital clinic about a month. During one of these clinical visits, it was suggested to him that he apply for disability benefits at the Social Security office. He did not wait long (about 15 or 20 minutes) for his initial interview at this office. The Social Security representative was very courteous and patient with him. He does not remember the disability program being explained to him. He recalls being told that if his legs are so bad that he could not work he might qualify for benefits.

The Social Security representative completed all the necessary applications and other papers for the applicant and mailed the request for the medical records directly to the hospital. The hospital did not charge him for the medical records since he was an outpatient and attended the clinic regularly.

The State vocational rehabilitation agency, prior to making the disability determination, sent Mr. ——— to another doctor. The beneficiary stated that he was satisfied that he received a thorough examination from the doctor and was treated very courteously.

Mr. ——— stated that he had contacted the Social Security office at least three times since initiating his claim and he was treated very

courteously each time. He does not think that he is strong enough to work.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

Mr. ——— was interviewed on December 16, 1959 at his residence. Mr. ——— said he is 63 years old and has not worked since September 15, 1958. He seemed to walk well but said he cannot mow his own lawn. He is receiving a \$53 a month Veterans' Administration pension for World War I injuries.

Mr. ——— said he found out about the social security disability program from his labor union. He said he was treated well by the people in the Social Security district office and could not say enough about how good they were to him. He said he may have waited about 5 minutes or so in the district office before someone talked to him and he was treated very nicely.

He feels that everything about the disability program and his rights under it were fully explained to him by the interviewing person including the fact that he had to be totally disabled and not able to carry on his own type of work before he could qualify for social security disability benefits.

Mr. ——— said that the district office people encouraged him to file an application for disability benefits because he had a letter from his doctor stating he was totally disabled.

Mr. ——— said that the person at the district office filled in the application forms from information supplied by him and that he signed the forms. Mr. ——— said he does not remember if he was given a medical report form to give to his doctor or whether the district office mailed the form to the doctor but he was not charged for the preparation of the form. His doctor actually examined him at the time of preparing the medical report. He does not know if he was charged for this examination as he was going to his doctor twice a week at that time. He said the district office sent him to a clinic for an examination. He said the doctor had received a medical report form from the district office. He was not charged for this examination. He did not take or mail a medical report form to other doctors. The district office called him to visit the office for another interview and he was told the office had received the doctor's report.

He feels he had all the assistance necessary at the district office in preparing his claim for disability benefits. He was not assisted by any other person or organization.

He said he had no other comments on his treatment by the district office. He feels he was well treated and the people were courteous and explained parts of the law covering disability.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed this 59-year-old applicant on December 23, 1959. Mr. ——— lives with his son in a small, sparsely furnished house. He seemed frank and sincere in replying to my questions. The applicant has been unemployed since September 1958.

Mr. ——— learned of the social security disability program from newspaper articles and radio news broadcasts. On his visits to the Social Security district office he never had to wait more than 15 minutes before a Social Security representative was able to see him. He stated that the Social Security personnel were very nice to him and were always courteous. Social Security representatives never explained the disability program, the rights under it, and the disability requirements to the applicant. Social Security personnel helped Mr. ——— file his application and gave him a medical report to take to his doctor. His doctor prepared the report without giving him a physical examination since the applicant was currently under the doctor's care. Mr. ——— stated that he was charged the regular office fee for the visit to the doctor to prepare the report.

The State vocational rehabilitation agency sent the applicant to two physicians for examinations. He believed that the examinations given by these doctors were quite thorough.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed this applicant on January 5, 1960. Mrs. ——— is 59 years old and although born in the United States she was taken to Poland by her parents at an early age and lived there for many years before returning to this country. The applicant lives with her family in a modest apartment. She was frank and sincere in replying to my questions.

Mrs. ——— learned of the social security disability program from reading Polish newspaper articles and from friends who also informed her of the location of the district office. On her visits to the district office she was always treated courteously by Social Security personnel and never waited more than 15 minutes before a representative talked to her. The disability program, the applicant's rights under it, and the extent of disability necessary to qualify for benefits were never explained to Mrs. ———. Her decision to file for benefits under the disability program was not influenced by Social Security representatives. The applicant did not receive any assistance from district office representatives in preparing her case. Mrs. ——— mailed requests for medical evidence to two hospitals and took one medical report form to her family physician. The doctor completed the medical report form from his medical file on the applicant and did not charge for its preparation.

Prior to making a disability determination the State vocational rehabilitation agency sent the applicant to two doctors for physical examinations. Mrs. ——— stated that she was treated courteously by both doctors.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicants Receiving Benefits

After two previous unsuccessful attempts at contacting the applicant, I interviewed him on January 4, 1960. Mr. ———, age 56, is single, has no dependents, and lives by himself in a one-room apartment on the second floor of a store building. The apartment was not very clean. The applicant stated he worked as a dinner and pastry cook for a good many years until 1942. He then worked wrapping medical supplies at an Army medical center, during World War II. Thereafter, for awhile he worked at odd jobs until sometime in 1956 when he became too ill to work. He reported that he is disabled by arthritis, heart trouble, eye trouble, and epilepsy, and is presently taking treatments at the hospital. The beneficiary moved about and participated in the interview with no visible difficulty. While he stated he was not working and his only means of support was \$65 per month relief from the county welfare agency, I got the impression from his attitude and some of his remarks that he might be withholding information with regard to working part time. His application for disability benefits has been approved but he is not receiving the benefits pending the furnishing of satisfactory evidence of age. On the day I interviewed him, he was sending to the Bureau of Census for the necessary evidence.

The county welfare agency told Mr. ——— about the disability program and where to go. He went to the district office to file his claim. He had to wait only about 20 minutes for someone to talk to him and was treated courteously. He said the disability program and his rights under it were fully explained to him. In describing how disabled he had to be to qualify for benefits, the district office told him he had to be too disabled to work. The district office people neither encouraged nor discouraged the applicant to file; they just asked question and filled out the application.

Mr. ——— stated that in addition to filling out his application the district office gave him a medical report form and sent him to a doctor for an examination. He stated the doctor checked him over but didn't charge him for the examination nor for filling out the medical report. After he first talked to the district office, he did not feel he needed additional assistance in preparing his claim and didn't obtain any.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I kept an appointment with Mr. ——— on January 4, 1960. He lives with his wife in a rundown tenement two-room apartment for which they pay \$10 per week rent. Mr. ——— is receiving

\$68 per month disability benefit. This income and his wife's income of \$33 per week make up their sole means of support. He is age 64 and she is about 61. Mr. ——— has not worked since February 1950. His regular occupation was as an ironworker on outside construction. In 1950 he contracted tuberculosis and because he was unable to do any kind of work both he and his wife had to go on public assistance. He stated that when he was finally granted disability benefits, he stopped getting public assistance payments. These public assistance payments were \$20 every 2 weeks.

The beneficiary stated that as a result of a newspaper article he had applied for disability benefits but his claim had been denied because his earnings were not current enough to meet the requirements then in force. He showed me a letter dated November 25, 1958, from the district office notifying him of the September 1958 change in the social security law. The letter indicated the possibility that a new claim might be favorably considered if he could meet the amended requirements.

The beneficiary stated that he had personally never called at the district office. His wife said that she went in his behalf and took the November 25, 1958, district office letter with her. The district office sent a field representative to see the claimant in December 1958. Both Mr. and Mrs. ——— said that the representative filled in all of the papers and that he was most courteous and helpful. At the time Mr. ——— could hardly get about, and he and his wife were very grateful because of the saving in expense and discomfort to them because of the personal visit by the district office representative.

The district office sent the claimant to a local physician and to a State doctor. The beneficiary does not recall the State doctor's name, and he does not know what contacts the district office made with the hospitals that had medical records on him. Mr. ——— said that he was never asked to pay a medical fee for either reports or examinations. Mr. and Mrs. ——— seemed satisfied with their treatment by the district office.

I asked the beneficiary whether he knew, either on the basis of his first experience when his claim had been denied or on the basis of the letter of November 25, 1958, which informed him on the September 1958 amendments, how disabled he had to be in order to qualify for benefits. He answered that he was well aware all along that a man must be so seriously ill that he cannot do any kind of work. I believe that he understood the reason for his first denial was due to lack of current earnings. He explained to me his understanding of his later allowance by stating he supposed that Social Security wanted to give him credit for earnings for past years instead of insisting upon the earnings being recent.

I thanked them for their cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I telephoned this 63 year old applicant and made an appointment to see him. He lives with his wife in a neat well-furnished brick row house. Mr. ——— wore very thick eyeglasses and it appeared that

his eyes were very sensitive to light. His eyes watered continually throughout the interview. Aside from his visual disability Mr. ——— seemed in good physical condition. The interview was conducted in the presence of his wife, who on several occasions furnished her husband with information concerning dates of his hospitalization and the approximate date of filing the original application. Mr. ——— was very cooperative and tried to give as complete answers to the questions as possible.

Mr. ——— explained that prior to the onset of the disability, he had had two operations for cataracts. He said that the last operation was performed in June 1958. Mr. ——— stated that approximately 2 months later he was accidentally hit across the eyes by a fellow worker at the factory where he was employed as a tailor. He was treated by his ophthalmologist, and was operated on by another doctor for a retinal detachment in October 1959.

He said that he has paid into the fund since the inception of the social security program. He said that he had learned about the disability program from a patient in the hospital. In February 1959, approximately 6 weeks after he was discharged from the hospital, he went to a Social Security contact station and filed an application for disability. He said that the field representative at the contact station helped him fill out the application. However, Mr. ——— could not remember if he was advised of his rights and the procedure to appeal an adverse decision. He said that he was treated courteously. Mr. ——— said that the Social Security representative told him to call the district office if he did not get information on his claim within 6 weeks. Mr. ——— said that after approximately 2 months had elapsed he called the district office. He said that on May 5, 1959, several days after his call, a Social Security representative came to his house to discuss his claim and gave him three copies of the medical report forms to be completed for medical evidence. Mr. ——— said he mailed a copy of the report forms to the two doctors and a hospital. He stated that he was not examined at the time the medical reports were prepared but that he had made regular visits to both doctors before and after the medical forms were prepared.

Mr. ——— stated that in October 1959, a representative of the Blind Association visited him and asked if he was interested in learning handicraft work. He said that he told the representative that his eyes were giving him too much trouble and that he felt that he could not do the work.

Mr. ——— said that he was well pleased with the way he was treated by the district office and by their field representative and with the way his case was handled.

I thanked them for their cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I was able to contact this 64-year-old applicant by telephone and made an appointment to see him at his home. Mr. ——— is a rather thin, mild mannered man who lives with his wife in a neat, well-furnished brick row house. He was very courteous and cooperative

and in my opinion he gave reliable information. His claim was allowed approximately 3 months after he made application for disability benefits.

Mr. ——— stated that he had been employed as a streetcar operator. He said that on June 25, 1959, the company doctor put him on the company's disability rolls. The doctor explained to him that because of his bad heart condition the people who rode in his streetcar were placed in jeopardy. Mr. ——— said that a few days later he visited his physician, a heart specialist, and he was advised to apply for social security disability pension. He said that Dr. ——— had been treating him for the past 5 years. He said that after consulting a telephone directory he went to the district office and applied for disability benefits. He stated that he did not have to wait long and was treated very courteously. He believed that the disability program and his rights under it were fully explained to him. He was informed that to receive benefits he must be totally disabled which meant unable to work.

Mr. ——— said that the Social Security representative asked him a number of questions and filled out the application for him. He said that the representative gave him a blank medical report to be prepared and submitted by his doctor as medical evidence. He added that the claim representative advised him to call the district office if he did not get any word on his claim within approximately 6 weeks. Mr. ——— stated that he took the medical form to Dr. ——— on his next visit. He said that he was given the usual examination and was charged for the regular office call but was not charged for the preparation of the medical report. Approximately 1 month later, Mr. ——— called the district office to learn the status of his claim. He said that he was advised that his case was being considered by the State agency and that he would receive a decision in the near future. Mr. ——— said that his claim was allowed on September 18, 1959. He stated that he was very pleased with the way he was treated by the district office people and with the way his claim was processed.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed Mr. ——— at his home on December 21, 1959. He is a thin, small man with a pale complexion. He lives with his wife in a small frame house which they rented for \$32 a month. His wife, who appeared to be domineering toward her husband, took an active part in the interview and at times contradicted his statements. After the questionnaire was completed I reviewed with them the information that I had recorded. They concurred in the recorded data. I believe the information to be reasonably correct.

Mr. ——— said that he worked for a local company until he was stricken with a heart attack. He said that he was confined at a hospital, and was treated by Dr. ———. He said that since he was unable to work and had no income, he applied for public welfare in December 1958. He stated that he was receiving this financial aid when he applied for social security disability.

Mr. ——— said that he read about the disability program in the newspapers and gathered some information on it from his friends. However, he said that he applied for disability in March 1959 on the advice of the State welfare department. His wife maintained that he was forced by the welfare department to apply. Mr. ——— explained that under public assistance he was receiving \$95.80 a month and free medical care and medicines but under the disability program he was now receiving only \$94 a month and had to pay for all his medical expenses. He pointed out that in effect his monthly income had been reduced because he required medical care and medicine constantly.

Mr. ——— said that in March 1959, he went to the district office and made application for disability benefits. He stated that he did not have to wait long, the disability requirements were adequately described to him, he was encouraged to file, and he was treated courteously.

Mr. ——— stated that the Social Security representative read questions to him and completed the application. He was informed that he had to be totally disabled to get social security benefits. He said that in either April or May 1959, the district office mailed to him two copies of the medical report to be submitted as medical evidence. Mr. ——— said that his doctor filled out a medical report after giving him an examination. He said he did not pay for the preparation of the medical report or the examination. He said that he mailed the other medical form to the hospital. He stated that in July 1959, he was notified by letter from the State agency to go to a heart specialist for an examination. Mr. ——— said that he was notified in September 1959 that his claim was allowed. He mentioned that he was well pleased with the way his claim was handled.

He stated that he received his first check in October 1959 and it was for \$933.70 which included benefits retroactive to December 1958. He said that he returned the welfare check that he received in October. He pointed out that a few days after he received his social security check an adjuster from the welfare department came to his house to ask for reimbursement for State aid. He said that he received welfare checks from December 1958 to September 1959. He stated that he repaid \$600 to the welfare department. Mr. ——— showed me an itemized list of his recurring monthly expenses. The list showed that his monthly expenses, exclusive of food, exceeded his monthly disability benefits by approximately \$7. He said food was purchased by delaying payments on some of the other expenses. He stated that he found it hard to live on his disability benefits.

I thanked them for their cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I interviewed Mr. ——— at his home on December 31, 1959. He lives with his wife in an attractive single house which they moved into about 2 weeks prior to the interview. He is 55 years old and very limited in his activity. He moved very slowly and was unsteady in his gait. Several times he required assistance from his wife in

order to move about the room and he appeared to tire easily. He stated that he had a poor memory and that he required his wife's assistance in supplying information on his claim. His wife supplied practically all the information to which he gave his concurrence by nodding his head or stating "That's right" or "yes." He spoke slowly and sometimes stammered.

He said for the past 2 years he had been receiving sick pay from the insurance company he had worked for and that he expected these benefits to be terminated within the next few months. His wife said that he could have applied earlier for disability but that he was reluctant to do so because of personal pride. To this he remarked, "I felt that I would be asking for assistance of some kind." His claim was allowed approximately 6 months after they first contacted the district office. He is presently receiving \$116 a month.

His wife stated that they were advised of the disability program by his sister, who was receiving monthly social security benefits. In March 1959, she visited the district office and gave the representative general information concerning her husband's disability. She said that she did not have to wait long and was treated courteously. On May 4, 1959, a social security representative came to their home and assisted them in filing an application. Neither Mr. — nor his wife could remember whether the representative explained to them the disability program or how disabled the applicant had to be to qualify. However, they stated that he seemed interested in the case and encouraged them to file.

Several days later they received a copy of the medical report through the mail. Mr. — took the report to his family physician on his next regular visit and was examined at that time. He was not charged for either the examination or the preparation of the medical form. Later he was referred by the State agency to Dr. —, a heart specialist, who took a cardiogram. He also was given an examination by another doctor to determine his general physical condition and the condition of his arteries. Mr. — stated that the examinations showed that his heart was all right, but that he had arteriosclerosis which limited his activity. They felt that they did not need additional assistance in preparing the claim. They received no assistance from other persons or organizations. Mrs. — repeated that they were well pleased with the cooperation of the district office people and with the way her husband's claim was processed.

I thanked them for their cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

Mrs. — was interviewed on December 29, 1959, in her fifth-floor apartment where she lives with her husband. She appeared to be in good health but she is partially blind.

Mrs. — said she found out about the disability program through the Jewish Guild for the Blind. She went to the Social Security district office to inquire about disability benefits and subsequently a Social Security representative came out to see her. She felt she

had been treated well by Social Security district office personnel. The claimant said she did not have to wait long before someone talked to her and explained the disability program and her rights under it.

The beneficiary said the district office people encouraged her to file an application and furnished her the information she requested. She was given the necessary medical report forms which she mailed to her doctor. She said he made no charge for its preparation. She said her doctor examined her at this time but did not charge for it. She said she did not send a report form to other doctors but that the district office obtained reports on her case from four other doctors.

She said that she did not need additional assistance after talking to the district office. She had no general comments to make about how the district office had treated her.

Mrs. ——— said she has been employed on a part-time basis for the past 7 years at the Jewish Guild for the Blind and that she earns \$12 weekly.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I telephoned Mrs. ——— for an appointment and subsequently interviewed her on December 18, 1959.

The claimant appeared to be well educated and had previously been a legal stenographer. Her husband is a retired post office employee and they live in their own home in a nice residential neighborhood. The claimant was neatly dressed and her home was tidy. She stated that because of her heart condition she cannot work or travel anywhere alone. She goes out about once or twice a week with her husband to do some shopping or take an occasional ride. The rest of the week she stays home.

Mrs. ——— learned about the disability program while employed in a law office. She went to the Social Security district office. She waited about 10 minutes for an interview and was treated courteously. Although the disability program and her rights under it were not fully explained, she did receive a booklet telling her about the program. Mrs. ——— stated that because she had been a legal stenographer, the claims representative probably assumed that she knew about the program. The representative encouraged her to file an application for disability benefits.

The district office representative filled out her application. She was given a medical report form which she mailed to her doctor who completed the report and returned it to the district office. She was not charged for the preparation of the medical report. The claimant was not examined by her own doctor at this time as she was under his constant care. She did not mail a report to any other doctor. She had no other comments to make about her treatment by the district office.

Mrs. ——— stated that she was sent to a doctor for an examination. She was well satisfied with his examination.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

The beneficiary was interviewed on December 28, 1959. He lives with his wife. He said he was injured in right leg during First World War.

The beneficiary said he found out about the Social Security disability program through a news item in a local newspaper and after further inquiry he went to the local district office. He did not have to wait long for someone to see him. The disability program and his rights under it were fully explained to him.

Mr. ——— said that the district office people neither encouraged nor discouraged him from filing an application. They gave him information about the program so he could decide if he should file a claim. He said he received clerical help in filing his application at the district office. Mr. ——— said he obtained his medical proofs from his doctor and that he was sent to another doctor to be X-rayed. He took the medical report form to his doctor and was examined at this time. He was not charged for the medical report or the visit. He did not take or mail a report form to any other doctors and does not know whether the district office obtained other reports on his case from other sources.

Mr. ——— said that after he first talked to the district office, he did not feel he needed additional assistance in preparing his claim and received none.

The applicant said he is unemployed.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I telephoned Mr. ——— and made an appointment to see him on December 24, 1959. He was pleasant, sincere, and cooperative. Mr. ——— stated he and his wife would answer our questions as accurately as possible. They lived in a large walkup apartment house in a nice neighborhood. Their apartment was on the fourth floor and Mrs. ——— said that they were looking for a smaller apartment on the ground floor. Mr. ——— stated that the climb up to his apartment was very tiring for him, so therefore he did not go out very often. Mr. ——— told us that he had night blindness and had limited side vision. He said that he could not go out in the evenings unless he had someone with him. He could not drive a car because of his poor eyesight. He has a veteran's non-service-connected disability and receives a veteran's pension of \$66.15 a month in addition to his social security disability benefits. Mr. ——— told us that he used to work in the fur industry but because of his present condition this type of work is too strenuous for him.

While Mr. ——— was a patient in the veterans' hospital, one of his fellow patients told him about the social security disability program and advised him to file an application for disability benefits. After Mr. ——— had been discharged from the hospital, he and his wife went to the Social Security district office to file an application

for disability benefits. He knew the address of his district office. Mr. and Mrs. ——— waited about 30 minutes before they saw a district office representative who treated them very courteously. They stated that he explained the disability program and their rights under it to them. However, they both felt that they did not receive sufficient explanation of the degree of disability necessary before a person became eligible for benefits. The representative gave Mr. and Mrs. ——— information about the program and let them decide themselves about filing. Mr. ——— filed the application. He had intended to file even before he talked to a representative of the district office.

The representative filled out Mr. ——— application. Mr. ——— explained his case history to the representative and the district office requested his medical history from the veterans' hospital. He was not required to take an examination nor was he charged by the hospital for the medical report it submitted. Mr. ——— stated that he was also examined by two doctors recommended either by Social Security or the State welfare department. One was an eye specialist and the other was a heart specialist. Mr. ——— was pleased with the doctors and the examinations. He thinks that he took the medical reports to the two doctors and that they told him they would complete the reports and mail them to the proper office.

Mr. ——— could not understand why he had been requested to go to the Social Security district office three times. He was treated courteously each time.

I thanked them for their cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I made an appointment by telephone to interview this beneficiary on December 18, 1959. He lives on the first floor of a two-family house in a very nice neighborhood. He and his wife were present at the interview and they both cooperated in answering our questions. The applicant appeared to be in poor health. He coughed intermittently and said that his lungs bothered him.

Mr. ——— found out about the social security disability program from his union. They gave him the district office address. He and his wife went to the district office where they waited about 20 minutes before speaking to a claims representative who treated them very courteously. He explained only part of the disability program to them and then gave them a booklet to read at home. He encouraged Mr. ——— to file an application for disability benefits.

The claims representative filled out Mr. ——— application. The beneficiary requested medical proofs from his own doctor and his hospital. He took the medical report forms to his doctor and his hospital; and they prepared the reports and mailed them. He was not charged for the preparation of the medical report or for the examination his own physician gave him before completing the medical report. Before a determination was made on his case, Mr. ——— stated that he was sent to a doctor recommended by the district office for a complete examination. This doctor mailed a medical report to the district office.

Mr. ——— did not obtain any further assistance in preparing his claim because he felt it unnecessary.

The claimant made no other comments on his treatment at the district office. He felt that the people at the district office knew their job and treated him fairly.

I thanked them for their cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I made an appointment to see the beneficiary December 23, 1959. He lives with his wife in their seven-room home. Mrs. ——— was also present at the interview. Both cooperated fully. Mr. ——— wore a hearing aid during the interview. He said that he had been employed as a painter until he stopped working on the advice of two doctors. They told him that climbing up and down a ladder was too strenuous for his heart. He must carry his heart pills with him whenever he leaves the house. He is now receiving a veteran's non-service-connected pension of \$66.15 per month in addition to his social security benefits.

Mr. ——— heard about the social security disability program while he was a patient in the hospital. The doctor who was treating him at the hospital told him about the program. He knew where his district office was located and sent his wife to obtain an application form. Mrs. ——— was treated very impolitely at the district office and was given very little information about the disability program. After Mr. ——— left the hospital, he requested the district office to send a representative to see him. About 2 months later a Social Security representative came to his house. The representative treated him courteously and explained the disability program and his rights under it to him and his wife. He believes that the representative described how disabled he had to be to qualify for benefits. However, he did recall that the representative encouraged him to file a disability claim.

The representative filled out the application for him. Mr. ——— obtained his medical proofs from his family doctor, a heart specialist, and from the doctor at the hospital. Mr. ——— took the medical report form to the doctors who prepared them without charge. The doctors did not examine him because he was then under their care.

Mr. ——— was sent to another heart specialist for an examination. This doctor gave him a thorough examination. Mr. ——— was not charged for this examination and he believes that this doctor sent a medical report form to the district office.

Mr. ——— did not feel that he needed additional assistance in preparing his claim. He made no other general comment about his treatment by the district office except that he felt that the representative who came to see him had helped him considerably.

I thanked them for their cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

The beneficiary was interviewed in his home on December 30, 1959. He said he was ordered by his doctor to do no work because of his heart condition. The claimant said that he is unemployed.

Mr. ——— said he does not recall who told him about the social security disability program. Mr. ——— said that he did not wait long for someone to consider his case and that he was treated courteously. The disability program and his rights under it were fully explained to him and he was told that he would have to be totally disabled to qualify for benefits. The claimant said that the district office people encouraged him to file an application and furnished him all information requested. He said the district office assisted him in preparing his case and obtained some medical proofs for him.

Mr. ——— said he sent a report form to one doctor and that the district office also obtained a report from a doctor. Mr. ——— said he had no other comments to make about his treatment by the district office.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

Mrs. ——— was interviewed on December 17, 1959, in her home. She appeared frail and sickly and did not move around the house very well. She said she learned about the social security disability program from some friend of hers and, after further inquiry, went to the district office.

The beneficiary said she did not wait long before someone at the district office considered her case. She stated that she was treated courteously and that the disability program and her rights under it were fully explained to her. She said the district office people said that she would have to be totally disabled to qualify. The beneficiary said the Social Security representative neither encouraged nor discouraged her to file an application but gave her information so that she could decide herself.

Mrs. ——— said she received every assistance and that the Social Security representative filled out the application for her. She said she requested medical proofs from the hospital. She said her doctor actually examined her at this time but did not charge for it. The beneficiary does not know whether the district office obtained reports on her case from other sources.

Mrs. ——— said that after she first talked to the district office she did not feel she needed additional assistance in preparing her claim and received none. She had no general comments to make about her treatment by the district office. The claimant said that she was unemployed.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Receiving Benefits

I kept an appointment with Mr. ——— at his home on December 21, 1959. He is 63 years old and lives with his wife. Mr. ——— is a stocky man and seemed in good health. He is somewhat hard of hearing but had no difficulty with the interview. He answered the questions frankly and in voluble English, broken with an Italian accent.

Mr. ——— worked as a laborer and general helper in a local contracting firm. When he was on the job a cement block hit him on the head. He was hospitalized for 5 weeks with a cerebral concussion.

The applicant first found out about the disability program through his wife. Mr. and Mrs. ——— went to the Social Security office and inquired about disability benefits. They made only two visits. Mr. ——— said that in both visits to the district office he and his wife were treated courteously; they did not have to wait more than a couple of minutes. A female representative explained to them during the first visit how disabled he had to be in order to qualify. She told him that if he did qualify he would not be paid anything for 6 months. He said that he asked questions and felt that he had a good idea of what to expect. He did not believe that the representative tried either to encourage or discourage him to file for disability benefits.

The Social Security representative helped him fill in certain papers and asked him to get his birth certificate. On the second visit he was given papers to take to his family doctor. Mr. ——— said that he went to Dr. ——— because this doctor had attended him many times and he considered him his family doctor.

Mr. ——— said that Dr. ——— did not charge him either for filling out the form or for making examinations. Some time after the visit to his family doctor, the district office sent the beneficiary a letter containing a medical form which he was asked to take to a person he called "a Social Security doctor." He said this doctor examined him for about 1 hour and charged him nothing for filling in the form or for the examination. He expressed his full satisfaction with every aspect of his contacts with the district office.

I thanked him for his cooperation.

DENIED APPLICANTS

INTERVIEW REPORT

Denied Applicant—No Appeal Made

Mr. ——— was interviewed on December 12, 1959, at his residence. Mrs. ——— was present during the interview. Mr. ——— said he is 64 years old and has not worked since May 9, 1958. He does not seem disappointed at not being given a favorable reply to his disability application. He said his arthritis comes and goes in severity. He moved about the room without any apparent difficulty.

Mr. ——— said he heard about the social security disability program from fellow employees at his company. He also read about it in the newspapers. The Social Security district office was quite busy when he arrived to file a disability application, he said, and he had to wait about an hour before someone talked to him; however, he was treated very nicely. The district office representative told him all about the disability program and explained to him how a disability claim is processed. The representative did not say how handicapped he had to be to qualify for disability benefits. The representative put down everything he said about his arthritis and he decided for himself that he wanted to file a disability application for benefits.

Mr. ——— said the district office representative filled in disability application forms from what he told her about his disability. He

then signed the forms. He said the representative gave him a medical report form to take to his family doctor for preparation. The doctor did not charge him for this service and he was not examined by the doctor at this time. He said about 2 months after he took the medical report form to his family doctor the social security district office sent him a letter requesting him to go to a specified doctor for full examination and X-rays. He has no way of knowing if the district office received medical forms from his or other doctors.

Mr. ——— feels he had sufficient assistance from the district office and did not have help from any other person or organization. He had no other comment to make on his treatment by the district office except to say that he believes the people did all they could for him.

Mr. ——— said he is satisfied with the decision to deny his claim for disability benefits which he received in the form of a letter from the Social Security Administration and that he has not had any further contact with the district office. He said he felt indifferent about approval of his claim.

He said he is receiving one-half his regular salary from his company while on sick leave and until his company pension begins in September 1960. If he did receive social security disability benefits his company would only pay him one-half his regular salary less any amount which he received from Social Security in disability benefits.

He said he will not reopen his case as he has only a short time before he is eligible for social security old-age insurance benefits.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied applicant—No appeal made

I was able to contact this 62-year-old applicant by telephone and made an appointment to see him December 4, 1959. He lives with his wife in a modest and very neat cottage. Mr. ——— says he has spinal arthritis that at times renders him completely helpless. Mr. ———, with a long record of employment in the construction field, claims he rarely lost a day's work due to illness until recent years. Mr. ——— is a well-built, intelligent looking man.

Mr. ——— said that he learned of the disability program from the newspaper. Mr. ——— said that his doctor advised him to file for a disability benefit.

Mr. ——— went personally to the social security district office. He waited about 1 hour and generally seemed well pleased with the district office service. Other than receiving a pamphlet describing the disability program he received no other explanation from the Social Security representative. He said the Social Security representative was vague as to how disabled he had to be to get a benefit. Mr. ——— seemed to attribute this vagueness to his impairment—arthritis. Mr. ——— said that the Social Security representative did not influence his decision to file a claim.

The Social Security representative filled out the forms, asking Mr. ——— the necessary questions. Mr. ——— took his medical report form to an orthopedic physician who gave him an examination and filled out his report. The doctor charged him \$10 which is his

regular charge for a physical examination. Mr. ——— did not submit any other medical reports nor did the district office secure any for him. Mr. ——— said he didn't need help in filing his claim and did not seek assistance from other persons or organizations. Mr. ——— emphasized that he thought the Social Security representative was very courteous.

After Mr. ——— received his denial notice he felt that it would be a waste of time to pursue the matter further. Mr. ——— said that the denial notice had very little explanation but said this is probably the usual procedure for Government notices. Mr. ——— did not again contact the district office and never appealed his denial.

Mr. ——— feels that the present requirements for a disability benefit are too rigid and only reaches a fraction of the people who need benefits. He is under the impression that you have to be practically dead to qualify for benefits. He said that he heard that if you are well enough to be able to go to the bathroom you can't get benefits. Mr. ——— believes that with his age and disability he will never work again. Mr. ——— said he is living on savings but shows concern over his future welfare.

I thanked them for their courtesy.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I interviewed this 61-year-old applicant on December 17, 1959. Outwardly, the applicant did not appear to have any obvious physical defect but during the interview she complained of getting chest pains, and fainting and coughing spells. Mrs. ——— has two sons but does not want to rely on them for her support as she feels that they have difficulty meeting their own financial obligations. The applicant is presently unemployed.

Mrs. ——— learned of the social security disability program from her physician who suggested that she file a claim for benefits. She learned of the address of the nearest Social Security office from a friend who was receiving disability benefits. She waited 5 or 10 minutes before a Social Security representative saw her. The applicant stated that she was treated very courteously by Social Security personnel. The disability program was never explained to her, but, in regard to the extent of disability necessary to qualify for benefits, she was told that a person would have to be 99 percent disabled. The only assistance given by the Social Security representative related to filling out the application and furnishing medical report forms. Mrs. ——— took the medical report form to her doctor who gave her an examination. The doctor did not charge her for filling out the medical report but did charge for the examination. She also sent a medical report form to a hospital where she had been treated.

The State vocational rehabilitation agency sent Mrs. ——— to Dr. ——— before making the disability determination. She received the notice of denial on September 10, 1959, and shortly after receiving it went to the Social Security district office where her rights were explained to her satisfaction. The Social Security representative did not attempt to influence her decision about an appeal in any way.

Mrs. ——— is still undecided about making an appeal.
I thanked her for her cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I was able to meet Mrs. ——— at her home on December 9, 1959. Mrs. ——— and her son share a dingy apartment in an old rundown house in a small rural town. Her impairment is such that she cannot hold down a job and her son suffers from epileptic seizures and a spinal impairment both of which prevent him from working regularly. She stated that they depend on the assistance they receive from the public welfare agency plus the meager income her son gets from sporadic employment.

Mrs. ——— learned about the disability program through the local newspaper but the public welfare agency actually instructed her when and where to file. She and her son went to the district office together and on one occasion, when confined to her bed, a Social Security representative came to see her at her home. The applicant had no complaints as to how she was treated at the district office. She stated she only waited about 10 or 15 minutes before being waited on and then the people who talked to her were most courteous. Mrs. ——— claimed the disability program was explained to her, to a degree, but assured me no mention was made as to how disabled she had to be to qualify. The applicant stated no influence was asserted by the district office whether she should file or not; the decision was left up to her.

Mrs. ——— stated that no help was offered her in preparing her case and she requested none. Between her and her son, they were able to complete the application without too much trouble. The district office gave her a medical report form which she took to her family doctor. The doctor filled out the form and sent it to the district office for which he billed her \$4. Mrs. ——— stated she was not given an examination on this occasion, but felt the doctor was thoroughly familiar with her case since she was his regular patient.

The applicant stated Social Security sent her to two other doctors and also requested that she allow them to secure medical information from a hospital where she had spent some time. All of this was done without charge she explained.

Mrs. ——— was far from satisfied when she received her denial letter but actually did nothing at the time. She is ignorant of the fact that she had any recourse now that she had been denied and is resigned to the fact that she is not "sick enough" to receive benefits. When I advised her during the interview that she was entitled to a hearing with legal representation if she desired, she stated that "what's the use" since it would probably be a waste of time.

I thanked her for her cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I interviewed the 53-year-old applicant on December 30, 1959. Mr. ——— lives with his family in a one-room apartment. He has been

unemployed since January 1957 and is presently receiving State aid. His replies to my questions seemed sincere.

Mr. ——— learned of the social security disability program from newspaper articles. The applicant, however, did not go to the Social Security district office of his own volition but received a letter from the district office requesting him to come in. When he went to the district office the Social Security representative would not tell him how they had learned of his case. The applicant had been receiving State aid and he believes that the caseworker turned his name over to the Social Security district office in an attempt to remove him from the State aid rolls and place him on the Federal disability rolls. He waited 45 minutes before a Social Security representative saw him. Mr. ——— stated that although he did not go to the district office with the intention of filing an application he was induced to file an application because the representative led him to believe that he would be entitled to benefits. The applicant stated that he later found out that "a person had to be 99 percent dead" to be eligible for benefits. Although the disability program was explained to him, he was not told how disabled he had to be in order to qualify for benefits. The applicant also stated that the representative would not answer his question relating to whether his State aid benefits would be affected by Federal disability benefits. He also stated that the representative that filled out his application was not only discourteous to him but was also a "liar."

Mr. ——— did not obtain a medical report from a doctor of his own choosing as he could not pay for a doctor's services. The district office arranged for an examination that was given by a doctor connected with the State welfare program. The applicant stated that he was not satisfied that he received a proper examination as the only thing the doctor did was to make a visual examination of his hernia. To his knowledge no other medical evidence was obtained for his claim.

Mr. ——— has not taken any action since he received the notice of denial. He believes that judgment was passed on his claim without a proper physical examination and intends to submit additional medical evidence from a doctor of his own choosing as soon as he can afford to pay for a doctor's services.

During the interview Mr. ——— stated several times that he intends to present his experiences in connection with his application for social security disability benefits to one of the local newspapers.

I thanked him for his cooperation.

ATTACHMENT TO INTERVIEW REPORT (BASED ON OUR REVIEW OF CLAIMS FOLDER)

The applicant alleges that judgment was passed on his claim without a proper physical examination. He further asserted the only thing the doctor did was to make a visual examination of his hernia.

Reference to the applicant's folder disclosed the following facts:

The report prepared by a Social Security representative said, "* * * although he washes clothes by machine, makes beds, mops, does some cooking, dries and washes the dishes, and takes care of a 3-year-old baby, he states that he could do no work." The medical

report from a clinic shows that after an initial medical examination the applicant did not return for additional tests as instructed. The denial determination was based on this one medical report which failed to show a severe disability.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

Mrs. ——— was interviewed on December 24, 1959, at her residence. Mrs. ——— said she is 61 years old, a widow, and is not presently working. For a period of time, she said, she was receiving social security payments for herself and minor child from her deceased husband's social security account.

Mrs. ——— said she heard from friends about the social security disability program. She said she called the Social Security district office about filing an application for disability benefits and a field representative came to her home and talked with her. She did say that she was treated courteously by the field representative.

Mrs. ——— said the disability program and her rights under it were fully explained to her and she was told that if she was awarded disability benefits and later went back to work they would be stopped. She does not believe the field representative described how disabled she had to be to qualify for social security disability benefits. The representative kept asking if she was then working. She said she has decided she wanted to file an application for disability benefits and did so.

Mrs. ——— said the field representative gave her disability application forms to fill in, sign, and return to the district office which she did. She said she received, by mail, a medical report form from the district office to take to her doctor to have prepared. At this time the doctor examined her. She was charged for the examination but not for the preparation of the report. She did not take or mail a medical report form to other doctors. Mrs. ——— said she needed no assistance in preparing her claim for social security disability benefits.

She had no other comments on her treatment by the district office representative, except that the questions were stupid. She did not elaborate.

Mrs. ——— said she was not satisfied with the letter she received from Social Security Administration denying her claim for disability benefits. She said no reason was given her except that she was ineligible to receive disability benefits. She said she filed her application in November or December 1958 and the denial letter was received about 6 months later.

She took no action after receiving the denial letter, she said, as she was then feeling fine and did not wish to pursue the matter further. She did not believe it would do any good anyway. It took so long, she said, on first application that if she refiled she might be dead by the time the new application was approved.

I thanked her for her cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

Mr. ——— was interviewed on December 10, 1959 at his residence. Mr. ——— said he is 59 years old and is not working. He is living in a cheap roominghouse. Shortly after the start of the interview Mr. ——— launched into a tirade of obscene language against the Social Security Administration and the local Social Security district office. He appears mad at the world. During the interview he frequently became excited but when he calmed down gave, seemingly, intelligent answers.

Mr. ——— said he read about the disability program of social security in the newspapers after he broke his hip in February 1953. Mr. ——— said that when he visited the Social Security district office he only had to wait minutes before someone talked to him and he was treated courteously. He is sure the district office representative fully explained the disability program to him and his rights under the program. The representative did not describe how disabled he had to be to qualify for disability benefits.

At this time Mr. ——— became angry and said he has paid into social security for many years and feels he is entitled to disability benefits.

Mr. ——— said the district office gave him disability forms to fill in and he took them home to have his daughter help complete them. He said he was also given a medical report form which he took to his doctor for preparation. The doctor did not charge for the preparation of the report nor did he make an examination. He said he had been to so many doctors he cannot recall names, times, or places.

Mr. ——— said he felt he needed assistance in preparing his claim but he did not get it at the district office. He brought the application forms home to his daughter for help in preparation. His comments at this time about treatment at the district office are not repeatable or reportable. They were vitriolic.

Mr. ——— said he was in the hospital when he received the letter of denial of his claim. He has not yet reopened his case but he definitely will do something about the denial of his claim. He must eat, he said.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I met Mr. ——— at his home on December 10, 1959, as previously arranged by our letter. He and his wife live in a neat looking row house in a suburb. Mr. ——— apparently has no income of his own but he informs me his wife works in an effort to help out.

The applicant first became aware of the disability program through the newspaper. A neighbor told him where to find the district office and he went there by himself. On one occasion when his disability was particularly troublesome, preventing his going to the district office in person, a Social Security representative came out to visit him.

Mr. ——— told me that he never waited more than one-half hour when visiting the district office and that he was always treated most

courteously. He stated a Social Security representative patiently explained his rights under the disability program and further explained that in order to qualify for benefits a person had to be unable to perform any substantial work. The applicant emphasized that no one influenced him one way or other in regard to filing an application.

Mr. ——— asserted he did little on his own toward preparing his case. He stated a district office employee filled out the application by asking him questions and when finished he was asked to sign it. He was given a medical report form and instructed to take it to his doctor which he did. There was no charge for its preparation. The doctor did not examine him at that time since he had made many previous visits to his office. Mr. ——— remembers signing an authorization so that Social Security could obtain medical information from the hospital where he had been a patient.

Mr. ——— remarked he could never have prepared his case on his own. After he first talked to the district office he stated that he was at a complete loss as to what was expected of him. He reemphasized how kind the people at Social Security were and that they led him through the entire process.

The applicant stated he was surprised at the decision given his case. He stated he was unable and too old to work and therefore could not understand the reason for his denial. Mr. ——— claimed he called the district office and they told him he could request a hearing if he so desired. He had no idea how to proceed and did not have anyone to assist him so he decided to do nothing, at least at that time. He does not remember being told he could have a lawyer represent him but stated it would not have made any difference since he had no means to pay a lawyer anyway.

The applicant has been unable to work since 1956.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I made an appointment by telephone with Mrs. ——— for December 21, 1959. She lives with her family in a second-floor apartment. The applicant seemed to be frank and sincere in her replies to my questions. She has been unemployed for 3½ years.

The applicant learned of the social security disability program from a neighbor, who also informed her of the location of the nearest district office. On her visits to the Social Security district office, Mrs. ——— stated that 20 minutes was the longest that she ever had to wait before a representative took care of her. She stated that she has always been treated courteously by Social Security personnel. The disability program, her rights under it, and the disability requirements were never explained to her. The only assistance given to the applicant by Social Security representatives related to filling out the application and instructing her about furnishing medical proofs. The applicant took the medical report form to her family physician, who completed the report without giving the applicant an examination. She was not charged for the preparation of the report.

The State vocational rehabilitation agency sent the applicant to a "bone specialist" for examination; however, Mrs. ——— believes that she should have been sent to a "brain specialist." When she received the denial notice she was not satisfied as to the reasons given for her claim being denied, as she states that she is sick and unable to work. Mrs. ——— went to the district office, where she was told that if she was not satisfied, she could submit additional medical proof. Social Security personnel did not attempt to encourage or discourage the applicant about appealing her case. The applicant intends to submit additional medical evidence.

I thanked her for her cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I interviewed this 52-year-old applicant on December 17, 1959. He lives alone in a one-room apartment above a store. The apartment contained only very meager furnishings but was neat and clean. His room and board are donated to him in return for light custodial work at the apartment building. Mr. ——— moved about fairly well but with some noticeable impairment. The applicant is suffering from arthritis and gunshot wounds in the chest. He stated that he is getting treatments at the hospital, which are helping his arthritis but he still can hardly walk sometimes. He also stated that it is hard for him to breathe at times because of the estimated 30 shotgun pellets in his chest near his heart. He reported that the doctor informed him that the shots could not be removed. Mr. ——— was pleasant and courteous during the interview. He seemed honest and sincere in his statements and was not angry or bitter because of having been denied benefits. The applicant worked for the railroad until November 1955 but has had no regular job since then.

Mr. ——— found out about the disability program from the newspaper. He went to the Social Security district office to file his claim for benefits. An acquaintance already receiving benefits told him where to go. The applicant reported that he had to wait 2 or 3 hours for someone to talk to him in the district office but the Social Security representatives were courteous to him. He stated, however, that these representatives did not explain fully to him the disability program or his rights under it. Neither did they tell him how disabled he would have to be to qualify for benefits. Mr. ——— further stated that the district office people did not encourage or discourage him from filing but merely assisted him in filling out the application.

Mr. ——— was of the opinion that the district office wrote the Railroad Retirement Board for proof of age but this proof was not good enough. His memory seemed to be vague as to whether the district office then sent out to the Veterans' Administration hospital for his Army discharge to be used as proof of birth or whether he went out and got it. He believed they sent out for it. He took the medical report form out to the doctor at a hospital. The doctor took X-ray pictures and examined his heart before filling out the form. The applicant was not charged for either the examination or preparation of the medical report. He did not take or mail the report form to any

other doctor. Mr. ——— was not certain but he thought the district office might have obtained some medical reports from the Veterans' Administration hospital. The applicant stated he was discharged from the Army in 1943 because of arthritis. He further stated he felt the need of additional assistance in preparing his claim but did not obtain any. He was not informed in either of his two interviews at the district office that he could have representation at a hearing before a referee of the Appeals Council.

Mr. ——— did not blame Social Security for his denial of benefits but believed it was due to the doctor's report being incorrect since he is not able to hold down a regular job. He has taken no further action on his denial because he felt he had to go through too much redtape. I do not believe the applicant knew what to do next. I informed him that if he was not satisfied with the denial, he could contact the district office and tell them and they would tell him what to do.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—Appeal Made

I interviewed the applicant on January 4, 1960. Mr. ———, 58 years old, is single and lives in a 1-room apartment on the first floor of an old, rundown apartment building. His apartment contained very few furnishings and was not very clean. The applicant reported that he worked as a janitor and porter for about 33 years. He has been out of work since 1953. He stated his disability consisted mainly of epilepsy and arthritis. He remarked that he also had trouble with his leg which was broken some time ago.

The applicant seemed to move about without much difficulty and sat in a chair for the interview. He did not seem very industrious and I believe he might be willing to accept benefits rather than try very hard to do light work even if he were able. He stated, however, that he was unable to get a job which he could do and that his only means of support was the \$65 per month relief he received from the welfare agency. He also stated that he first applied for disability benefits some time in 1958.

Mr. ———'s doctor first told him about the disability program. His doctor also told him where to go to file his claim. He only had to wait one-half hour at the district office for someone to talk to him and he was treated courteously. The applicant did not remember very well whether the disability program and his rights under it were explained to him but he believed they were. He asserted, however, that the district office did not describe how disabled he had to be to qualify for benefits. The district office people did not encourage or discourage him from filing. They just asked if he was too disabled to work; and when he said, "Yes," they merely filled out the application for him to sign.

In addition to filling out his application, the district office sent Mr. ——— a notice directing him to go to three doctors for examinations but did not send him any medical report forms to take to them. Mr. ——— reported that all three doctors examined him but none of them charged him for the examination or for preparation of a report. He did not know if the district office obtained a report from the hos-

pital where he had been a patient. He stated that after he first talked to the district office, he felt he needed additional assistance in preparing his claim but didn't obtain any.

When Mr. ——— received his denial letter from Social Security, he was not satisfied as to the reason his claim was denied because he was unable to work or get a job and he felt he was entitled to benefits. Upon the advice of a welfare worker he filed another application in December 1959. Although he contended that the district office did not say why his claim was denied, he commented that the representative told him not to worry and that he would get benefits but it may take a little time. While Mr. ——— alleged he was not told that he could appeal his case or submit additional medical evidence, I am inclined to think he may have filed a request for a hearing in December 1959 instead of filing another application. I do not believe he knew for certain what additional action he did take; I think he mainly just knew he took some further action to try to get his claim allowed. He showed me a Notice of Determination, dated September 29, 1959, notifying him of the denial of benefits as a result of additional information received, and superseding a prior determination. This notice may have been the result of a reconsideration even though the applicant did not seem to be aware he had one.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I kept an appointment with Mr. ——— on January 5, 1960. The interview took 1½ hours. Mr. ——— is 58 years old and lives with his wife on an 80-acre farm which he owns. The house was neat and clean. Mrs. ———, age 45, sat in on the interview and confirmed most of the applicant's remarks. The applicant was up, dressed, moved about some, sat in a chair and participated in the interview with no visible difficulty but gave the appearance of a man who was not entirely well. Mr. ——— reported that he had been disabled since October 1958 by a heart condition, consisting of an enlarged heart and a heart valve that didn't function properly and by a hernia that aggravated his heart condition. These defects for a long time caused him so much pain in his chest and arms when he moved that he couldn't do any work but had to remain still. He had a heart attack in June 1959. As a result of his condition, he was unable to put out any crop in either the spring or fall of 1959. His brothers planted some grass in May 1959 so that he would have feed for his cattle. His wife took care of the cattle last winter. Mr. ——— stated that he had continued taking treatments from his doctor as a result of which his heart condition was now some better and he could do part-time work around the farm. He and his wife now care for their 20 head of cattle. However, he did not know when, if ever, he would be able to do the heavy farmwork and carry on a full farming operation. During his period of disability, with the exception of a small amount of income from the sale of livestock, his wife's income from working has been their only means of support. Mrs. ——— worked at a defense plant 40 miles away until October 31, 1959, when she was laid off. Mr. ——— also worked there as a tool setter and

foreman from 1941 to 1945 and again from 1951 to 1954 when he had to give it up on account of his health. Although his doctor has expressed confidence his health could be restored to the point that he could do light work, the applicant was apprehensive that he would not be able to go out and get a job off the farm and stated that with present farm prices, he and his wife could not live on their income from the farm alone. The applicant expressed particular concern as to whether they would have enough to live on should his wife no longer be able to work.

Mr. ——— found out about the disability program from the newspapers and from his income tax man. A notice in his local newspaper informed him of the time that the Social Security representative would visit his contact station. The first time he went to see the representative he estimated he had to wait one-half hour before he could talk to him; the second time he kept an appointment and didn't have to wait at all. He was treated courteously both times. Mr. ——— stated that the representative just asked questions and did not explain the disability program or his rights under it. Neither did the representative give him any literature explaining the disability program. Furthermore, he did not explain how disabled he would have to be to qualify. The Social Security representative did not encourage or discourage him from filing but just filled out the application and the applicant signed it.

At the request of the Social Security representative, Mr. ——— took medical report forms to his two doctors. He also mailed a medical form to the hospital, where he had been a patient. No charge was made by either doctor for filling out the report nor for an examination for the report. The Social Security people also sent the applicant to Dr. ——— for an examination at no charge to him. Mr. ——— did not feel he needed assistance in preparing his claim but felt he needed some in arriving at his allowable earnings. He did not understand why the Social Security representative excluded some of his farm income. He felt he should have had someone represent him in computing his earnings for benefit purposes, but he was not told he could have his income tax man or anyone else to represent him. He stated that his income tax man has told him that income was excluded which should not have been.

Mr. ——— stated that the denial notice he received from Social Security was not specific enough as to why his disability did not qualify him for benefits and he was not satisfied as to the reason his claim was denied. He has taken no action as yet. I got the impression that the applicant was not pressing his claim because he was feeling better and was waiting to see if he recovered sufficiently to run his farm, in which case he would not bother to appeal because he was rather discouraged from not getting benefits.

Mr. ——— believes the disability program is very disillusioning. He explained that people contributed to the program believing they will be protected in the event of disability and then find they have nothing when the need arises. He felt that the program should cover people with a disability over a considerable period of time even if they ultimately are able to return to work. He wondered what they would have done if his wife had not been able to work or what other people would do if their wives weren't able to work.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied applicant—No appeal made

Mr. ———, age 59, lives in a small hotel on the edge of the downtown district, has a temporary job as doorman at a theater, and when able to work, earns \$28.40 weekly. Several attempts were made to contact Mr. ——— but due to his odd working hours, I was unable to make an appointment until he complied with my written request to telephone me at home and we made an appointment for the following Saturday morning. I therefore interviewed the applicant in his hotel room on December 19, 1959. The interview took about 1½ hours. Mr. ——— was cooperative, but at the same time he appeared bitter since he could not make a living or work at his trade (steamfitting) and still was denied disability benefits.

Mr. ——— stated he first heard of the social security disability program while a member of the pipefitters union. He filed his application at the social security contact station, where a Social Security representative came twice weekly. He said he had to wait about 45 minutes for his first interview and the representative was very nice. The same party sent him a notice to meet him for further questions about 60 days after the application was made out. He said his rights were explained to him, as far as he knew them, at the time he filed; but the Social Security representative did not explain his appeal rights. He did not recall a statement by the representative as to the degree of disability necessary to establish his claim. He stated that his daughter encouraged him to file for disability benefits. He did believe he had sufficient data to make up his own mind but agreed with his daughter.

Mr. ——— stated the Social Security representative was courteous, filled in the application form, and read some excerpts from Social Security folders and books. In regard to medical reports, he said he had gone "to about 18 doctors" and gave this information to the Social Security office. For current and local medical proof he said he had a physical examination by Dr. ———. He had no personal knowledge of any reports from other doctors, hospitals, or institutions. He said he did have the feeling of needing additional assistance after his first interview but did not know where to get it. He also commented that the district office was not much help and told him it looked like there was not much use in his having filed.

Regarding the denial, he was not satisfied as to reasons given, but has taken no action for reconsideration or a hearing. He says he was not told he could appeal except in the denial letter, which also advised him that he could submit additional medical proof. The district office was not contacted after denial. He stated he had no knowledge of his right to legal or other representation at a hearing or that he could appear "in person" or let the referee decide on the record.

His final comment was that he had been a steamfitter about 45 years and has pinched nerves which preclude his working at his trade or anything else by which he can make a living. He doesn't feel he will be given any consideration as long as he has any income, but he has spent all his savings and is giving serious consideration to a request

for a hearing and possibly getting a lawyer if he can make financial arrangements with one.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

Mr. ——— was interviewed on December 10, 1959, at his residence. Mr. ———, who said he is 58 years old and has not worked for 2 years lives in a small rented house in an older section of town. He was assisted in rising and seating by his wife, who was present during the interview.

Mr. ——— said that other patients at the hospital informed him about the social security disability program, and he decided to file an application. Mr. ——— said that when he visited the Social Security district office he did not have to wait long to see a representative, being called within 10 minutes and he definitely was treated very well and with all courtesy. He said that, to his knowledge, he believes he had explained to him fully his rights under the disability program. The representative did not explain to him, nor did he ask, how disabled he had to be to qualify for benefits under the social security disability program. The decision to file an application for disability benefits was entirely his own.

Mr. ——— said the district office representative filled in information on application forms from facts given by him. Mr. ——— said the district office sent him to two doctors for a physical examination and X-rays. The medical report forms were apparently mailed by the district office to the doctors. He said he was not charged by the doctors for the medical report preparation or the examination. Mr. ——— feels he did not need additional assistance in preparing his disability claim and did not seek help from any other person or organization.

Mr. ——— said he is not satisfied with the letter of denial received by him from Social Security. He has not taken any action on the denial but said when he is well enough he plans to visit the district office and request a hearing. He is disappointed about being denied benefits. He was in an automobile accident since the receipt of the denial and has been unable to visit the district office.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

Mr. ——— was interviewed on December 15, 1959, at his residence.

Mr. ——— said he is 65 years old and has not worked since October 1957. He lives in a war housing project which is being gradually demolished. The applicant is hard of hearing and has difficulty understanding. His wife was present during the interview and helped clarify some answers and questions. These were repeated to him and he nodded his head in agreement.

Mr. ——— learned about the social security disability program from an old friend of his and had also read about it in a local newspaper.

Mr. ——— said that when he visited the district office he did not have to wait more than 15 or 20 minutes before someone talked to him and he was treated well and very courteously. He believes he was given a full explanation of the disability program and his rights under it. He thinks he was told by the district office representative that he had to be over 50-percent disabled before he could qualify for social security disability benefits. He said he made up his own mind to file an application for disability benefits.

After he moved, his case was transferred to another district office and Mr. ——— said the second district office called him in to file an application for disability benefits. The district office representative filled in the application forms from information Mr. ——— furnished them. He brought with him a medical report form from his own doctor. He does not know if the district office obtained reports on his case from doctors. After he signed the application forms at the district office he was told to go home and that he would hear from them.

He said he did not need additional assistance in preparing his claim as he felt the district office helped him sufficiently. Therefore, he did not have help from any other person or organization. He had no other comments on his treatment by the second district office except to say he was treated very nicely.

Mr. ——— said he is not satisfied with the letter of denial of his claim which he received from the Social Security Administration. He thinks he should receive disability benefits. He said he had done nothing further about reopening his claim for disability benefits.

His case is not arteriosclerosis, he said. He was injured while handling ammunition at an Army Ordnance Depot. He broke his leg and blood clots formed. He was operated on for removal of clots at a Veterans' Administration hospital. He receives a Veterans' Administration disability pension of \$66.15.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I was finally able to find Mr. ——— at his home on December 4, 1959, after two previous unsuccessful attempts. This applicant lives in a rather neat-looking apartment over a barber shop in a poor section of the city. He has received some assistance from Public Welfare as well as from his relatives. Mr. ——— is able to do some light work at times, but finds this difficult to find and when his heart condition acts up can do little or nothing. Mr. ———'s outward appearance gives the impression he is tired and worn out. He seems very despondent and rather belligerent toward the Social Security Administration. He doesn't seem satisfied with the denial decision. His comments seem to reflect a "What's the use" attitude.

Mr. ——— is not sure whether he first heard about the disability program through a friend or through the Public Welfare. His friend told him, however, where to find the Social Security office. The office was nearly empty when he arrived and therefore he was waited on within 20 minutes. He said the young lady at the district office was certainly kind and courteous enough and he has certainly no complaints on how he was treated. Mr. ——— stated his disability pro-

gram rights were explained to him but most of it "went in one ear and out the other." He was sure that no one explained "how bad off you must be to get paid."

Mr. ——— stated the people at the district office told him what to do and asked questions but Public Welfare took care of most of the details. Public Welfare sent him to a doctor and also asked him if they could get reports from the hospital where he had been a patient. According to Mr. ——— he was not charged for this or any other medical examination.

Mr. ——— said he was shocked at being denied and is now under the impression you must be at death's door to receive anything from the disability program. Public Welfare explained to him that he was denied benefits because his disability was not bad enough to prevent him from doing some light work. The claimant stated he wished they would find him a job doing light work. Mr. ——— stated Public Welfare told him he should go back to the Social Security district office and they would explain his rights relative to a hearing but he felt it useless and stayed away from the district office.

The claimant seemed very evasive regarding work but he did say light work, the kind he was able to do, was scarce since there were many young able-bodied men eager to do work of any kind. He stated the amount he earned was little and not worth the effort.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

Mr. ——— was interviewed on December 14, 1959, at his residence. Mr. ——— said he is 59 years old, married, and is currently employed as an apartment house owner and manager. He expects little profit, maybe about \$2,500, this year. His wife was present during the interview. Both Mr. and Mrs. ——— were very pleasant and cooperative but the interview with regard to answering the specific questions was not very successful because both of them had very little knowledge about the disability program. Referring to the disability program, Mr. ——— summed up the interview with the following comment, "We were treated wonderfully but do not know anything about it." They had a difficult time distinguishing between the State program and the social security program.

Mr. ——— explained that his company retired him because of his disability. He said that the personnel department took care of everything for him including starting his claim for both State and social security disability benefits. He said that he was unaware of what the program was because it was handled mainly by the company and he was not asking for anything.

He did not go to a Social Security district office but a very nice representative did come to see him. Mr. ——— said that he was very much impressed with the "young man" and that he was very "personable." Although he was not sure, Mr. ——— said that the representative did explain the circumstances under which he could receive benefits and he said that no one has explained how disabled he had to be to qualify. He said the representative was "neutral" as to whether he should file or not file but seemed to feel that it would be worth filing because "you never can tell."

Mr. ——— said the application was filled out in his home by the representative. He also received a couple of letters which they thought were from the State. One of the letters included a medical form which Mrs. ——— took to a doctor. He was not charged for the preparation of any forms nor for any examinations and other than the form that Mrs. ——— took to the doctor, they did not take or mail any forms to any other doctors. He is not sure if the district office obtained the reports on his case but he is inclined to think not because his company gave him disability benefits and so did the State but Social Security did not. He thinks they "missed the boat."

He was asked if he told the representative about being treated by the company doctor and he said "certainly." He did not know if the district office contacted the company doctor. He said that other than his employer, he was not assisted by any other organization. He did not feel he needed any additional assistance.

Mr. ——— was noncommittal about whether the denial letter from Social Security satisfied him or not; he said he didn't recall that it went into much detail. To date he has not done anything further about his claim. Mr. ——— inquired as to where he would go if he wanted to reopen his case. He was told to go to the Social Security district office.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

Mr. ——— and his wife were in when I arrived at their home on December 15, 1959, as prearranged through our letter. They live in a well kept small cottage in a small town.

Mr. ——— first learned of the disability program through television, and a local post office employee directed him to the district office. Mr. ——— stated he only waited a half hour when he visited the district office but seemed to think this unreasonable since no one was ahead of him. He does not believe he was treated courteously during the interview. Mr. ——— got the impression that the Social Security representative thought he was there attempting to get something for nothing. The Social Security employee contradicted himself on several occasions, Mr. ——— stated. This made the explanation of the disability program and his rights under the program very confusing, Mr. ——— explained. The applicant does not remember being told just how disabled you must be to qualify under social security standards but got the impression you had to be practically bedridden before you had a chance. Mr. ——— was about ready to give up the idea of filing at this point but decided to file anyway. No one directly encouraged or discouraged him from filing, the applicant stated.

Mr. ——— emphasized he received all the assistance he needed in preparing his case. The Social Security representative actually filled out the application, Mr. ——— explained and give him a medical report form to take to his family doctor. The applicant stated the doctor completed the medical report after giving him a medical examination and charged \$15 for the examination and filling out of the medical report. Mr. ——— understood that Social Security sought

additional medical information from a hospital where he was once a patient.

The applicant stated after he first talked to the district office he was thoroughly confused and felt he needed additional information and assistance. This assistance was readily given him. In summing up his treatment he received upon his visit to the district office, Mr. — named two criticisms. First, he doesn't believe he was treated courteously since he was forced to wait when there was no apparent cause for the delay. Secondly, the attitude of the district office people gave him the impression he was seeking public relief.

When the denial letter reached Mr. — he was not surprised since he had already gotten the idea you had to be "half dead" to qualify. The applicant called the Social Security office about 2 weeks after receiving the letter however and was informed in a discourteous manner that he could request a hearing and have a lawyer represent him. Mr. — stated that he was not informed that a referee could review the case based on the evidence in his file. The applicant explained that he was so utterly disgusted and discouraged at the time he let the entire thing drop. Mr. — feels he was given a bad decision since he was told he could not work by his doctor and has not done so since 1954. Even if he were stronger he doesn't feel he could find the type of job Social Security claims he could do. He has two strong able-bodied sons who cannot find jobs and a wife who is eager to help but cannot secure employment.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I interviewed the applicant on January 6, 1960. Mr. —, 54 years old, lives with his wife in a large old home. The house was neat, clean, and comfortably furnished. He was a stout, robust-looking man. Mr. — stated he had worked continuously since he was 14 years old until he suffered a heart attack on January 7, 1959. He still can't drive a car very far. Mr. — reported that his wife had been working as a practical nurse for the last 13 years and was at work at the time of my interview. He stated he did not know what they would do if she was not working. He said he had spent \$1,500 for doctor bills and needed to get his teeth pulled but didn't have the money. While his credit is good, he asserted he hesitated to go in debt because he did not know when he would be able to go back to work and pay it off. He reported that they rent a few rooms upstairs in their home to help out with the living expenses.

Mr. — found out about the disability program from the newspapers. It was published in the local newspaper when the Social Security representative would be at the contact station. His wife first went to the contact station in February or March 1959, while he was ill, and was given an application and a medical report form. The representative treated Mrs. — courteously and helped her fill out a portion of the application. She then took it home, and the applicant completed it and mailed it in. She took the medical report form to

their doctor. On the second contact with the Social Security representative, in May 1959, Mr. ——— kept an appointment to see him at the contact station. The disability program and his rights under it were fully explained to him, and he also was given pamphlets. In describing how disabled he needed to be to qualify for benefits, the representative merely told him that he had to be too disabled to work. The representative did not encourage or discourage him from filing but cautioned him not to misrepresent anything.

The only help the applicant received in filing was from his wife and the representative in filling out his application, as stated above. Mr. ——— informed me he was currently being treated by his doctor and he did not know if the doctor examined him specifically for the medical report. He assumed most of the information was taken from his records. He was not charged for either an examination for the report nor for its preparation. Mr. ——— said that Social Security sent him in the first part of August 1959 to Dr. ——— for an examination without charge to him. The applicant stated this was a waste of his time and the Government's money. He further stated that Dr. ——— made him feel like he was a deadbeat for trying to get benefits. This doctor's diagnosis was contrary to the diagnosis of other doctors; he told the patient he didn't have a heart condition. Mr. ——— did not feel Dr. ——— gave him an appropriate examination for his condition. Mr. ——— advised that Social Security also may have obtained reports from the Veterans' Administration hospital where he was treated in January and February 1959 for heart trouble, following his heart attack. He stated that a Veterans' Administration doctor told him he definitely could not exert himself anymore. The applicant did not feel he needed any additional assistance in preparing his claim and did not obtain any. He did not recall if he was told he could have a lawyer or someone else to represent him before the Social Security representative at the contact station. He was well pleased with this representative and felt he did all that was necessary.

The denial letter from Social Security did not satisfy Mr. ——— as to the reason his claim was denied. He stated it was not specific enough; it did not say why his disability did not qualify him. He felt he should receive benefits because he is unable to work. He has taken no action as yet but is contemplating doing so if he still is unable to work before the 6 months expires during which he may appeal.

The general attitude of the applicant toward the disability program seemed to be one of disappointment and being let down. He stated he had paid social security taxes ever since it started. He thought it was like an insurance policy but now when he can't work and needs benefits he can't get any. He reported he had used up all of his savings and needs the benefits. He stated he does not know how long it will be before he is able to work. His doctor has told him he could do light work, but he has been unable to get such a job. A State rehabilitation agency employee came to see him in October 1959 and told him that they could get him a job but the applicant hasn't heard from him since. Mr. ——— seemed very willing to do any kind of work he could get. I got the impression, however, that he was not qualified for office work.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

On December 14, 1959, I interviewed Mr. ——— at his home. He lived alone in a neat, small framehouse furnished by his son. Mr. ——— has a heart condition and congestion of the lungs. The applicant is a veteran of World War I and receives a pension of \$66.15 a month. He showed me the notice allowing his VA claim which states "evidence of record reveals that your disability prevents you from following substantially gainful employment." His statements about his experience with the Social Security office seemed frank and sincere.

After Mr. ——— was sick for about 2 months, friends urged him to apply for disability benefits. He applied for disability benefits at the Social Security district office. The applicant was treated courteously and did not have to wait more than a few minutes before someone talked to him. His rights were never explained to him so that he could understand what they were. The district office never described how disabled you have to be to qualify. Mr. ——— stated that all they did was ask him a lot of questions. The questions ranged from how able he was to move around to how much medicine he was taking. The district office employees did not encourage or discourage him from filing an application but just let him make up his own mind.

Mr. ——— did not receive any help in filing his application. The district office gave him a medical form to take to his doctor to fill out. The doctor did not charge him for filling out the medical form and the doctor did not examine him at this time. He had been to the same doctor for a regular visit in the morning and brought the medical form for him to fill out in the afternoon. He did not have to take the medical form to any other doctors but employees in the Social Security district office told him that medical evidence was received from the hospital as well as the VA clinic where he was examined for his VA pension.

Mr. ——— was not satisfied with the denial letter he received from Social Security and visited the district office to discuss it with someone. He was told that to be allowed benefits his condition would have to be bad enough to prevent him from walking a couple of blocks without stopping. Mr. ——— did not understand this explanation because he claims his condition is this bad. He was told he could appeal his case but was not told that he could submit additional medical evidence. The district office employee didn't encourage him or discourage him from requesting a reconsideration.

Mr. ——— stated that he was not satisfied with the explanation given about his denial and started to visit the man who had helped him with his VA claim. He later decided that this man would not be able to advise him on a social security claim. Mr. ——— has not worked since December 1958.

INTERVIEW REPORT

Denial Applicant—No Appeal Made

On December 14, 1959, I interviewed Mrs. ——— at her home. Mrs. ——— lived in a house located in a poorer section of the city

with some other members of her family. She was not well educated and I had a difficult time making her understand my questions.

Mrs. ——— heard of the disability program on TV and through her doctor. She visited the district office of Social Security to file her application for disability benefits. She did not have to wait in the district office and was treated courteously. Mrs. ——— was never able to understand her rights under social security and stated that the district office employees never told her how disabled you have to be to qualify for benefits. The people in the district office encouraged her to file an application and filled out the application form for her. The district office employee mailed the medical form to her doctor. The doctor completed the form and returned it to the Social Security district office. He did not charge her for filling out the form and he did not examine her before he filled it out. The district office (Mrs. ——— was a little confused about this) arranged for another doctor to examine her in the same building as the district office. This examination was probably requested by the State rehabilitation agency. The doctor wanted to put a tube down her throat and Mrs. ——— refused to let the doctor do it. Mrs. ——— stated that she asked whether the tube would damage her throat and wanted to know if it would hurt. The doctor answered by saying he didn't rightly know whether it would or not. She says that with that kind of answer she refused to swallow the tube. She stated that she spits blood and did not want to damage her throat anymore than it is now.

Mrs. ——— then received a letter from Social Security refusing her claim because she would not let the doctor complete his examination. A field representative called at her home and told her if she wouldn't let the doctor put the tube down her throat he would not be able to do anything more for her. She knows the reason why her claim was denied but she is not satisfied. She has taken no further action. She thinks that by swallowing the tube she may endanger her life.

Her daughter who was present during part of the interview asked what further action could be taken and I told the daughter to discuss it with employees in the Social Security district office.

I thanked her for her cooperation.

ATTACHMENT TO INTERVIEW REPORT (BASED ON OUR REVIEW OF CLAIMS FOLDER)

The applicant stated that as part of the consultative examination the doctor wanted to put a tube down her throat and she refused to allow this. The applicant stated that she asked whether the tube would damage her throat and wanted to know if it would hurt. She asserted that the doctor answered by saying he didn't rightly know whether it would or not. The applicant stated that with that type of answer she refused to swallow the tube. She thinks that by swallowing the tube she may endanger her life.

We reviewed the applicant's claim file and found that Social Security secured medical evidence including an electrocardiograph, chest X-ray, and laboratory tests. This evidence did not disclose a severe impairment and they wanted to get a gastric analysis which the applicant was not willing to submit to. A representative from the State

vocational rehabilitation agency visited her and attempted to persuade her to undergo the tests. The denial was based on the premise that the available evidence did not disclose a severe impairment.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

Mr. ——— was interviewed on December 14, 1959, at his residence. Mr. ——— said he was born in Italy, is 55 years old and married. He has not worked since March 1956. He said he would like to work but he has been told he is too old and crippled. His wife and his son were present during the interview. They live in an old farmhouse. Mr. ——— was very emotional and excitable during the interview and had to be calmed occasionally by his son.

Mr. ——— said he went to the State employment office looking for work and found out about the disability program from pamphlets available at that office. He said that when he visited the Social Security district office the people there were quite busy and he had to wait about an hour before someone talked to him; however, he was treated very well and courteously. He said the disability program and his rights under it were fully explained to him and he was told he had to have 5 years' work in the last 10 years to qualify for disability benefits. He did have this prior to his accident on March 20, 1956, at his place of employment. He was also told that he had to be 99 $\frac{2}{3}$ percent disabled before he could qualify for disability benefits.

He said the district office discouraged him from filing because his doctor's medical report showed only a 50 percent disability but he decided to file anyway. He had his doctor's medical report with him at the time of filing his disability application.

Mr. ——— said the district office representative filled in disability application forms from information which he supplied. The district office mailed a medical report form to his doctor for preparation and Mr. ——— said he was not examined by the doctor or charged for the preparation of the report. He said he did not take or mail any medical report forms to other doctors and he has no way of knowing whether the district office obtained other medical reports. Mr. ——— said he feels he did not need additional assistance in preparing his application for disability benefits and, therefore, had no help from any other person or organization.

Mr. ——— said the letter he received from Social Security denying his claim did not satisfy him at all since it stated he had insufficient disability. He has taken no other action since receiving the letter but his son said he will have his father reopen the case before the end of the year.

Mr. ——— appeared hurt because of the denial. He feels it is useless to try again at the district office. He said he tore up the letter he received regarding his disability claim and did not want anything more to do with the claim. He does not want charity. He said he has paid into social security for years and he feels he is entitled to benefits.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—Appeal Made

I met Mr. ——— on December 17, 1959. He lives in a small frame dwelling in a small town. This place was neat but was little more than a shack. In my opinion, his comments were sincere and he honestly felt that he was entitled to a disability benefit. The disability determination states that he suffers from ulceration of the leg. Mr. ——— insisted on showing me his leg. I have no knowledge of this impairment; however, his leg looked awful and I readily believed him when he stated that he is lucky to be able to get 4 hours' sleep a night.

Mr. ——— first learned of the disability program through the veterans' hospital which he said found him to be totally disabled. He filed his claim for social security benefits at the Social Security office. He said that the district office took people in turn and he had to wait about 1½ hours.

The Social Security representative asked him questions from the application form. Mr. ——— stated that he did not receive any explanation of the disability program and the Social Security representative did not describe how disabled he had to be to qualify.

He furnished Social Security with a medical report which he personally took to his physician who did not charge for preparing the medical report. Mr. ——— got some additional medical evidence from the veterans' hospital. The applicant does not believe that Social Security got any additional evidence from other sources.

The applicant is very upset about his denial and said, "It looks like you have to die to get benefits." Mr. ——— commented that he knew of people who are better off than he is but are getting disability benefits. He considers himself totally and permanently disabled and feels that Social Security has given him the "run around." Mr. ——— did not appear to have any knowledge of his appeal rights and said that the Social Security representative never explained them to him.

Mr. ——— was not satisfied with the explanation given in the denial letter and stated that he filed for a reconsideration in September or October 1959. He has not heard anything since then but he expressed the hope that Social Security will give him something before he dies. Mr. ——— commented that the Social Security representative did not explain what takes place when an initial denial is reconsidered. He feels that the Social Security representative discouraged him but he stated that he needs the benefits and filed anyway.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I interviewed Mr. ——— on January 8, 1960, at his place of temporary employment. He was most cooperative and apparently glad to talk to someone about his case. He will be 52 years old in April 1960, has his wife with him in a trailer home, and has raised three children, all now married. He added he had some savings, now depleted. He served in the Navy from 1940-44, inclusive, and was given a medical discharge.

Mr. ——— stated, that as a veteran of World War II and drawing a 30-percent disability pension from the Veterans' Administration, he had known of the disability insurance program under Social Security for some time prior to filing and stated this is a common topic in Veterans' Administration hospitals. He went to the Social Security district office to file his claim. No Social Security representative called at his home. He did not recall how long he had to wait before someone in the Social Security office talked to him, but recalled the representative was a woman and she was very courteous. He said he had thought at the time of filing the application he had most everything explained, but until he received his letter of denial, did not understand he had the right to ask for reconsideration or any further steps in his behalf. He also said he was told some things that would qualify him under the disability program but was not told he must be totally disabled or unable to work. He stated the woman at the Social Security office did not encourage or discourage him, but he was told if he wanted to file it would be up to a board to decide whether or not he was qualified for benefits.

Mr. ——— said the Social Security representative asked the questions and filled in the answers on the application. He stated he signed it but didn't read the answers on the form. He gave the Social Security representative his medical history. He did not take medical reports to any doctor or hospital and assumed they obtained the data they required in their own way. He had no physical examination at the time of application. He had no knowledge of any reports obtained by the district office. He said after his talk to the district office representative and the filing of his application he felt insecure but did not know what was lacking or what to do about it. He had no assistance from any other person or organizations. As to his treatment by the district office, he said that outwardly they appeared competent. They asked for his Navy discharge. He told them he was warned when he received it never to let it get away from his possession. He informed the Social Security office he would bring it in for them to see but would not turn it over to them. That apparently wouldn't do, so he referred them to Navy personnel records and gave his C number to the representative.

He has taken no action since he was denied benefits. As indicated previously, the only information received regarding his right of appeal was in this letter. He repeated that no one had advised him of his rights to ask for reconsideration, hearing by the referee, appeal to the Council or action in Federal Courts, with attorney or other representation.

His current employment as a stock clerk at the store is on a 2 to 3 hours per day basis, if able, for which he is paid \$100 per month for full time and less in accordance with hours on the job. He said his employer is understanding; he can leave when he feels it necessary, and they take him home when he has a fainting spell, which occurs now and then. This has been his only job in 2 years and his only income other than his Veterans' Administration disability payment of \$55 per month.

Mr. ——— stated he appreciated the interest the committee was taking in the administration of the disability program, appreciated being advised of the additional steps he could take in supporting

his claim and intended to go back to the district office, review his case with them, and ask for reconsideration.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I made an appointment by telephone with the applicant for December 21, 1959. Mr. ——— lives in a neatly kept room in a run-down hotel. The applicant seemed to answer my questions with frankness and sincerity. He has been unemployed since June 1958.

Mr. ——— learned of the social security disability program from a social worker who suggested that he file an application for benefits. The social worker also furnished him with the address of the nearest Social Security district office. The applicant stated that he was always treated pleasantly and courteously by the district office personnel. Mr. ——— stated that the disability program and his rights under it were never explained to him by district office representatives. The applicant was also never informed by these representatives as to how disabled a person had to be to qualify for disability benefits. The only assistance given to the applicant was in filling out the application for him and possibly sending a medical report form to his hospital. Mr. ——— stated that when he was given the medical report forms he told the Social Security representative that he did not know any doctors and that he would not know where to take the medical report forms. He also told the representative that he was currently undergoing treatment as an outpatient at a hospital. He believes that the form was sent to the hospital, although he was never told by anyone at the hospital that it had been received or that he had to undergo an examination so that the report could be completed. Mr. ——— was never requested to furnish additional medical proof nor was he sent to a doctor by the State Vocational Rehabilitation Agency.

Since receiving his denial notice he has not contacted the Social Security district office. While Mr. ——— understands the reason for the denial he cannot understand the reasoning in the law which does not provide benefits for a person who is not working and needs the money. Mr. ——— has never inquired at the hospital as to whether he could work and he has not attempted to find employment as he does not feel right.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I made an appointment with this 52-year-old applicant for December 22, 1959. Mr. ——— lives in a shabby hotel room. The applicant appeared to respond to questions with frankness and sincerity. He has been unemployed for over 11½ years.

Mr. ——— learned of the social security disability program from newspaper articles and a friend. On his first visit to the Social Security district office he waited approximately 10 minutes before a Social Security District representative saw him. The applicant stated that

he had no complaints about the treatment he received from Social Security personnel. The disability program, his rights under it, and the disability requirements were never explained to the applicant by Social Security representatives. The only assistance given to Mr. ——— by Social Security personnel related to filling out the application and giving him a medical report form to take to his doctor. The applicant took the medical report form to his physician, who completed the report without a physical examination since the applicant was currently under his care. He was not charged for the preparation of the report.

The State Vocational Rehabilitation Agency sent the applicant to Dr. ——— for a physical examination. The applicant received the notice of denial in September 1959 and is satisfied with the reasons given for his claim being denied. He has not contacted the district office since receipt of the denial notice and does not intend to appeal his case.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—Appeal Made

Mr. ——— was interviewed on December 16, 1959, at his residence. Mr. ——— said he is 60 years old and has not worked since October 1957. He walks with a slight limp, is neat appearing, and is very much disappointed with the Social Security Administration. His wife was present during the interview.

Mr. ——— said he learned about the social security disability program from a friend and read about it in a local newspaper. Mr. ——— said that when he visited the Social Security district office he was treated very casually and waited about 10 to 15 minutes before someone talked to him. He said the district office representative was courteous enough but he feels he did not get cooperation. Mr. ——— said the disability program and his rights under it were fully explained to him. He said the representative told him he would have to be completely disabled and unable to do any kind of work before he could qualify for Social Security disability benefits. He was told he would have to be blind or totally crippled.

He feels that the district office more or less discouraged him from filing a disability application.

Mr. ——— said the person at the district office filled in application forms from information he provided. He signed the forms. He said the district office gave him a medical report form to have prepared by his doctor. He was not charged for the preparation of the form and his doctor did not examine him at this time. He was not given a medical report form to take or mail to other doctors and he has no way of knowing if the district office obtained reports on his case from doctors or hospitals. Mr. ——— said he felt he did not need additional assistance in preparing his claim for disability benefits as he believed the information he gave the district office was complete for the claim application. He said he had no help from any other person or organization. He had no other comments on his treatment by the district office except to say that he sat at home and waited for disposition of his case.

Mr. ——— said he was not satisfied with the reason for the denial of his application for disability benefits as explained in the letter of denial which he received from the Social Security district office. He said that he has reopened his case at the district office.

Mr. ——— said the district office people told him that his doctor gave an unsatisfactory report because he had not examined the applicant since the original treatment of the patient's disabilities. He said he understood what he was told at the district office and that is why he insisted on reopening his case. At this time, he said, the district office sent him to his own doctor for an examination for which he paid a fee. The district office also sent him a letter asking him to go to another doctor for a full and complete examination. He said that he did not pay for this examination. After reopening the case, he said, and getting the necessary additional medical examinations, he waited for a reply. He said he received a second letter of denial of his claim on September 22, 1959.

He said he has done nothing further about his claim and that he does not know what to do now except wait for old-age insurance benefits.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I interviewed the applicant on December 30, 1959. Mr. ——— who will be 62 years of age in April 1960, lives in a very poor section of the town with his daughter and six children. The daughter is separated from her husband and draws child aid from the State welfare agency. Mr. ——— is employed at a cafe (as a "flunky," he says.) When able he works 8 hours daily (6 days per week) and receives \$42 bimonthly, after deduction for social security and income tax.

Mr. ——— said a doctor to whom he went for an examination suggested he call at the Social Security office and file application for disability. He knew where the district office was located and applied there. No one came to his home from the Social Security office. He stated he was treated nicely by the Social Security representative and only had to wait about 30 minutes for an interview. He guessed they explained his rights but wasn't sure. He understood he had to be so disabled that he couldn't work. No one encouraged or discouraged his filing a disability claim.

Mr. ——— stated the Social Security representative filled in the application and sent a medical report to the doctor who had examined him previously. He was not charged for the preparation of the report. He was subsequently requested by the State rehabilitation agency to go to Dr. ——— for a physical examination. There was no charge for this examination. He knew of no other reports obtained by the Social Security district office. He did not feel the need for additional assistance after talking to the district office and did not request or obtain any.

Regarding his denial, Mr. ——— stated he did not agree with the ruling and would not beg if he didn't feel he had it coming. He has taken no action since the denial believing it would do no good. He

has not talked to the Social Security representative since the denial and said he was not informed, except by statement in the denial letter, that he could submit additional medical proof or be represented by an attorney at a hearing. He had not made up his mind at this time as to what future steps he will take to reopen the case.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I made an appointment by telephone with this 63-year-old applicant for December 18, 1959. Mr. ——— is presently unemployed and lives with his 86-year-old father in a second-floor apartment. The applicant was frank and sincere in his replies to the interviewer's questions.

Mr. ——— learned of the social security disability program from someone at the district office who contacted him shortly after his release from the State hospital, where he was treated for alcoholism. On his first visit to the Social Security district office he waited about 5 minutes before a Social Security representative saw him. The applicant stated that in all his contacts at the district office he was treated fairly and in a very courteous and friendly manner. Although Mr. ——— could not be sure he thought the disability program and his rights under it were explained to him. He stated that he is vague about this as the original visit was made 2½ years ago. The only assistance given by the Social Security representative related to filling out the application and assisting him in obtaining medical evidence. Mr. ——— went to a doctor who submitted his medical evidence. The doctor did not charge for the medical report but did make a charge for an examination.

The State vocational rehabilitation agency sent the applicant for two examinations. A physical examination was performed by one doctor and a psychiatric examination was performed by another doctor. The applicant received the notice of denial on September 25, 1959, and has not contacted the Social Security district office since then. He believes that it is futile to pursue the claim any further because of the present rules and regulations. He believes that he was treated fairly and he is aware of his right to appeal but does not intend to take any action.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I kept an appointment with Mr. ——— on January 5, 1960. Mr. ———, 59 years of age, lives with his wife. Mr. ———, who appeared healthy, has had 15 heart attacks since 1950, 8 of which occurred within the last 2 years. The applicant stated he had originally worked as a milkman but took less taxing work as his condition worsened. Mr. ——— and his wife both are unemployed and living off their savings accumulated prior to his last regular employment in December of 1958. Although the applicant's wife, who was present at the interview, repeatedly questioned her husband's answers and memory during the interview, I believe his comments were credible.

Mr. ——— stated that he learned of the disability program from a customer while he was working as a gas station attendant; the customer, who was receiving benefits, suggested that he contact the Social Security district office. The applicant stated he was treated courteously by the people in the district office and did not have to wait long before someone talked to him. He stated that the disability program and his rights under it were explained to his satisfaction. The applicant stated the Social Security representative told him that their function was just to process the application and did not try to influence him as to whether or not to file. Mr. ——— stated that the district office representative told him that the Baltimore office and the State agency make the disability determinations and that the district office has nothing to do with it. The applicant could not recall receiving any description as to how disabled a person must be to qualify.

Mr. ——— stated that the Social Security representative filled out his application while questioning him and he then signed it. The district office representative also gave him a medical report form and instructed the applicant to have his doctor complete the form and submit it on his behalf. Mr. ——— stated that he had been under his doctor's care for quite some time, and that the doctor filled out the report based on his medical history without giving him a current examination or charging him for preparing the report. Mr. ——— stated that he submitted no other medical reports and has no knowledge of any efforts on the part of the district office to obtain additional medical reports.

The applicant did not feel that he needed any additional assistance in preparing his claim; he stated that although he had no experience along these lines, he felt the district office employees would properly process his claim. Based on his experiences with the district office employees, he feels he has no criticism or praise of them, stating they just processed his claim based on his request.

The applicant stated that the denial letter he received from the Social Security Administration did not give a reason for his denial. The applicant showed me the denial letter dated September 10, 1959; the letter was a form letter addressed to the applicant, indicating that he was not considered totally and permanently disabled from all types of gainful employment, without any specific reference to his particular condition. He has never gone back to the Social Security district office.

I thanked them for their cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I interviewed this 55-year-old applicant at his home. He lives with his wife in a shabby, extremely untidy tenement in a slum area of the city.

When I visited Mr. ——— his wife was not at home. He informed me that she works from 10 a.m. to 10 p.m. every business day as a waitress and this provides their sole support. Mr. ——— said that he had not worked since several months before he had the accident which caused his disability in 1956 or 1957 (he was not completely sure of the year). He walks with a noticeable limp caused, he said, by injuries to the hip and the knee on the same leg. It is very difficult and painful

for him to go up or down stairs. He has to go very slowly on a level but I saw him do so without a cane. Mr. ——— said that he has tried to find work but that "no one will give me a job in my present condition." Mr. ——— said that because of his difficulty in climbing stairs he spends every day in his apartment reading and watching television since he is all alone while his wife is away working.

My observations and impressions regarding the interview are that the statements were made in good faith. Except for his leg injuries Mr. ——— seems healthy both mentally and physically. He mentioned several times his belief that he was denied social security benefits "because he hadn't paid in enough." Subsequent review of the applicant's claims file showed that he did not have enough earnings credited to his record to meet the work requirements for a disability benefit. However, a determination was made declaring the applicant capable of engaging in substantial gainful activity.

Mr. ——— stated that he and his wife first learned about the social security disability program from a nearby druggist who owns the tenement, and from another man living in the same building. These neighbors suggested that he go to a Social Security office and find out what Social Security could do for him. Following their neighbors' suggestion, Mrs. ——— went to the Social Security office nearest her place of employment. He said that he had never been to any district office to inquire about his disability benefits, and that all his contact with the district office was through his wife. He said that his wife told him that she had talked with a girl at the district office about his disability, otherwise, his wife had no further comments so Mr. ——— assumed his wife had been treated "all right." He did not say whether his wife was encouraged or discouraged to file an application.

About 1 month after his wife's first district office visit, a Social Security representative came to see him at home. Mr. ——— said that this representative spent at least 1 hour with him and filled out a number of papers after asking numerous questions. At this time, it was not possible for the applicant to submit any medical proofs of his own since the applicant never called in a personal physician to treat his injuries.

Mr. ——— stated that about 4 months after the representative's visit, Social Security sent a doctor to examine him at home. He did not pay for this examination. This is the only medical attention ever received from Social Security or from any outside source. He has not received any help from any welfare organization, veterans organization, or labor union.

The applicant finally was informed by letter that his claim was denied. He interpreted the letter to mean "he hadn't paid in enough" and concluded "that is it." I asked him if he knew, or if anyone from Social Security or elsewhere had ever told him that he still had the right to request a reconsideration of his claim and that he might have the opportunity to present further information, medical or of any other kind. He said he had no such information.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—Appeal Made

I interviewed Mr. ——— on January 6, 1960, at his residence. He will be 65 years of age in March 1960. Mr. ——— filed his application for social security disability in July 1959, and his letter of denial was dated in September 1959. He was not sure what to do next, as he stated he did not fully understand his rights until now.

The applicant said he found out about the program through his wife, who made inquiry after he had had an eye operation for removal of a cataract. His wife contacted the Social Security representative and he advised her what her husband should do to file his application. He went to the Social Security district office and waited about 1 hour to talk to someone. He was treated courteously by the Social Security office personnel, but said his rights under the program were not explained to him then as he knows them now. He was told he must be totally disabled and unable to work in order to qualify. The Social Security representative told him "it wouldn't do any harm to file", but didn't urge him.

Mr. ——— stated that the Social Security representative filled in the application form. Medical report forms were obtained by the applicant. He mailed one of the reports to the doctor and took another report to a second doctor. The doctors mailed the completed reports direct to the district office. He was not charged for either of the reports prepared from office records. He was told that the Social Security office would obtain a report from the Veterans' Administration hospital. He did not feel the need of additional assistance after his first talk to the Social Security representative and solicited none. He commented that the Social Security office and representative were very nice, up to the time his application was denied.

The applicant stated his letter of denial did not satisfy him nor did it explain the reasons for denial. He says the district office didn't explain the denial or reasons to him but suggested he refile. He now believes this meant to make application for reconsideration which he did in December 1959 and on which he has had no further notice. He reiterated that the local representative did not explain reconsideration originally or any further steps available under the act. He said the representative told him in refiling to get an additional medical report from his doctor, which he did, and the representative couldn't see how his "refiling could hurt anything".

Mr. ——— remarked that he has not been able to work for the past year due to his disability. He stated he is totally blind in one eye and sees with the other only when wearing thick lens glasses. He was uncertain as to his future actions regarding social security disability but was glad the committee was interested in seeing that those deserving benefits got it.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I interviewed Mr. ——— at his residence on December 30, 1959. He lives in a furnished home at the edge of the town. He was co-

operative and congenial, and there was no reason to doubt the credibility of his answers or other statements.

Mr. ——— stated that his doctor suggested he call on the Social Security district office. The Social Security office gave him a medical report for his doctor to fill out and assisted him in filling out his application for social security disability. No one from Social Security called at his home. He stated his rights under the program were not explained to him and neither was the extent of disability necessary to qualify. The only assistance by the Social Security office was in filling in the application, and the applicant was not discouraged or encouraged to file.

Mr. ——— obtained a medical report from his doctor, for filing with the application. About 3 weeks later he was sent to Dr. ——— by the State rehabilitation agency for a complete physical examination. He stated his doctor charged him \$3 for the office visit and filling in the medical report, but there was no charge by the State agency doctor. He stated he did not get any information about the disability program at the time he filed. He said he just answered questions and signed the application. He got no assistance from any organization. He said he was not happy about his examination by the State agency doctor and said that the doctor told him, in response to his questions, that it was his job and that of the Social Security office to ask the questions, not answer them. He didn't believe the examination was thorough, as a week later he discovered he had a hernia and thought the State agency doctor should have found it. He said the State agency doctor only took about 30 minutes for the examination.

Mr. ——— stated he was not satisfied as to the reasons for his application being denied; as his doctor has advised him against attempting to work. Having been in the furnace business, he still tinkers with them on call and estimated he earns about \$10 per week, maximum. He filed in August 1959 and was denied in September 1959. He has taken no action since the denial and says he only knows about his rights from his friends and from the form letter of denial. He has not seen a Social Security representative and has not decided at this time what further steps he will take. He will be 57 years of age in July 1960; and stated finally, "I don't see why I can't freeze my social security," and "I'm living on a little savings now, but think I should be eligible at 65 for all the benefits for which I've paid in while working." He was told to consult with the Social Security district office as to his further rights for social security disability benefits, as well as his old-age benefits at age 65.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

On December 16, 1959, I interviewed the applicant in her apartment. She appeared somewhat feeble.

The applicant said she learned of the disability program from the welfare department. She said she went to the Social Security district office and did not have to wait for someone to consider her case.

The disability program and her rights under it were not fully explained to her.

She said the district office neither encouraged nor discouraged her to file a claim. She was informed that any decision on her case could be appealed but she received no assistance from the district office in preparing her case. Mrs. ——— said she got her medical proofs directly from her hospital and that she took a medical report form to her doctor who made no charge for its preparation. The doctor examined her at the time but made no charge for the visit. She said she did not take or mail a report form to other doctors but the district office received a medical report from the welfare department. The applicant said she did not feel she needed additional assistance in preparing her claim and received none. Mrs. ——— said that she was treated courteously by the district office.

Mrs. ——— said the letter received from the Social Security did not satisfy her as to the reason her claim was denied but that she took no further action.

Mrs. ——— said that she is not presently working.

I thanked her for her cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

The applicant was interviewed in his home on December 17, 1959. Mr. ——— said that he had been out of work for 10 years but receives \$156 monthly from the welfare department. He said he did not recall how he learned of the disability program but that someone advised him to go to a Social Security office. A Social Security representative did not visit him. Mr. ——— said he had to wait about 2 hours before someone talked to him, however, he was treated courteously. The disability program and his rights were fully explained. He said he was informed that he would have to be totally disabled to qualify.

The applicant said the district office representative encouraged him to file an application and then prepared the application for him. He said the district office sent his medical report forms to his doctor. Mr. ——— said he was not charged for the preparation of the form and that the doctor did not examine him at the time. The applicant said he took or mailed a report to another doctor but could not recall his name. He said he did not know whether the district office obtained additional reports on his case from other sources.

Mr. ——— said he needed additional help after he first talked to the district office but that he did not receive any. He said he was treated nicely by the district office.

Mr. ——— said that the letter he received from the Social Security office did not satisfy him as to the reason his claim was denied but that he took no action and did not talk to the district office about the matter. The applicant said he did not request a hearing.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I arranged to see Mr. ——— on December 23, 1959.

Mr. ——— lives with his sister and her husband. His sister was present during the interview and she helped Mr. ——— with some of the answers. The applicant was very depressed since he was unable to work and he felt that he was a burden to his sister and her husband. He stated that his amputated leg was not completely healed. He has no income and he felt that he could not exist except for the help he is receiving from his sister and her husband. Mr. ——— and his sister were both courteous, sincere, and cooperative in answering our questions. The applicant will file for social security benefits when he reaches 65 but until then he will continue to try to get disability benefits. They both felt very strongly that he should be entitled to disability benefits.

Mr. ——— found out about the social security disability program through his State rehabilitation office. They gave him the address of his district office and advised him to file an application for disability benefits. He went with his sister to the district office and waited about 10 minutes before someone talked to them. The representative was very courteous but failed to explain the disability program and his rights under it to Mr. ———. He did, however, encourage him to file an application for a disability benefit.

The representative filled out his application. Mr. ——— requested medical reports from his doctor and the hospital. The hospital did not examine him at this time nor was he charged for the preparation of the medical report form. Dr. ——— examined the applicant before filling out the medical report form but did not charge him for the examination or for the preparation of the medical report.

Mr. ——— stated that the State rehabilitation office sent him to another doctor for an examination. He believed that the doctor mailed a medical report to the State rehabilitation office. The applicant was well satisfied with the doctor and the examination. He was not charged for the examination or for the preparation of the medical report.

Mr. ——— felt that he did not need any additional assistance in preparing his claim. He made no other comments about his treatment by the district office.

Although the letter Mr. ——— received from social security stated the reason his claim had been denied, he was not satisfied. He felt that he was entitled to the disability benefit and he intends to appeal his case in January.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

Mr. ——— was interviewed on December 11, 1959, at his residence. Although Mr. ——— was living at a low-price hotel in a slum area of the city, his room was neat and orderly. He was very cooperative and appeared to be very sincere. In fact, he appeared to be

glad to talk to someone. He said he has not worked since January 1, 1954.

Mr. ——— said he became aware of the disability program through a referral by the State welfare department to the Social Security district office. He went to the district office only once and that is all he has done. He said that at the district office "they treated me very, very nice" and he does not think he waited over "7 or 10 minutes" before seeing a representative. He does not remember the representative explaining his rights under the program. All he could remember was that he was asked routine questions. He was told that it was up to the doctors to decide whether he was disabled enough to draw benefits. He was not discouraged from filing an application for benefits.

Mr. ——— said that the district office representative filled out the application for benefits from information which he furnished. Mr. ——— said he does not have a regular doctor because he goes every 3 months to a free clinic. He did not receive a special examination at the clinic as a result of his claim and he was not charged for any service he received. He said that evidently the district office must have mailed the forms to the clinic because he had nothing to do with obtaining the medical proofs. He just gave the district office permission to get the medical proofs.

The only assistance he received from any other person or organization was his referral to the Social Security district office by the welfare department. He did not believe he needed further assistance. He said the people at the district office treated him very well and that they were very sociable and patient. Anything he did not understand they explained to him.

Mr. ——— said the denial letter he received did not satisfy him as to why his claim was denied. He does not understand how they expect him to work when he can't walk a block without being breathless. He said, "I can't get my breath; how can I work?" He said he has not been back to the district office or done anything further in connection with his claim.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

Mr. ——— was interviewed on December 10, 1959, at his residence. Although Mr. ——— commented several times about his heart condition, he outwardly appeared healthy. He said he has not worked for 2 years, but does have a little rental income. He was very cooperative.

Mr. ——— was unable to recall any specific source from which he found out about the disability program. He said that he had become aware of it from general knowledge. He knew where to go to file his claim because he had passed the Social Security district office many times. He said, "I guess I was lucky because I didn't wait over 20 minutes and was treated very nicely and courteously."

He could not remember if the district office representative explained his rights under the program but did recall being told that he had to be 50 years old. He also recalled that the representative

explained to him that he had to be totally disabled in order to qualify. He said the reason he went to the district office was to find out whether or not he was eligible for benefits and that the representative did not discourage him from filing his claim.

The district office, he said, did everything for him. They asked him a lot of questions and filled out his application. He said that he didn't do anything to get his medical proofs from his doctor. He had been going to the doctor for several years and had an examination shortly before he filed his claim but it was not specifically for social security purposes. He wasn't required to take any forms to his doctor or to any other doctor but he did have a physical examination by a doctor that was selected for him. He was not charged anything for the preparation of any forms or for his examination. He was not sure whether the district office obtained the information from his own doctor.

Mr. ——— said he did not receive any assistance from any other organization nor did he believe at any time that he needed further assistance.

Mr. ——— said that about a month after he had filed for his benefits, he received a letter from the district office explaining that everything was in order and that proof of his date of birth was required. From the explanation in the letter that everything was in order, he said, it looked to him as if he were going to get his benefits but he was later denied.

Mr. ——— said the denial letter that he received from Social Security did not satisfy him as to the reason his claim was denied. He said that he could not understand why they said he was not totally disabled when doctors had told him he was. He objected to the denial letter because it appeared to be a form letter and that it gave him a feeling that there was no consideration given to his individual case. He felt it was a routine denial.

Shortly after his denial, Mr. ——— said he visited the district office and the representative did tell him he could appeal his claim and submit additional evidence and he understood that he had 6 months in which to do it. The representative explained to him that the reason for his denial was because he was not totally disabled but he could not understand this because doctors had told him he was.

Mr. ——— said he intends to take further action on his claim. I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I interviewed this 52-year-old applicant at his residence on December 23, 1959. He lives with his wife and son in a five-room duplex apartment. The applicant appeared to be in good health at the interview. Mr. ——— stated that he had a heart attack and has a permanent disability of 50 to 60 percent for the rest of his life. He is an attorney and factory representative and is working part time and earning over \$100 per week.

Mr. ——— stated that after his cardiac attack, while he was convalescing, he ran down every possible lead where money would be legally due him because of his illness. He telephoned the Social

Security district office and requested that a Social Security representative come out to see him.

The representative came to his home in July 1959 and explained the disability program and the applicant's rights. Mr. ——— does not remember any explanation of exactly how disabled he had to be to qualify. Mention was made that the applicant had to be permanently and totally disabled. Mr. ——— stated that there was a doubt at the time whether he would be entitled to benefits. He felt that since there was nothing to lose he would file. The representative was very courteous. The representative asked the questions and wrote the applicant's answers on the application forms.

Mr. ——— stated that he took the medical report form, left by the representative, to his physician on his next visit. He was not charged for its preparation. The applicant did not see any other doctors in reference to this claim.

Mr. ——— stated that the denial letter he received in September 1959 did not satisfy him. He feels that he has a permanent disability of 50 to 60 percent for the rest of his life. He has not contacted the district office but he feels he will take legal action if he can find a basis for contesting the denial.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I interviewed this applicant at his residence on December 22, 1959. He lives with his wife and 10 children in a five room row house in one of the poorer sections of the city. The applicant moves slowly as if favoring his back. He claimed his back and right leg were troubling him at the time of the interview.

Mr. ——— stated that the welfare department gave him a letter to present to the Social Security district office. He presented the letter and was told to go home until he received a letter requesting him to appear again. He received the letter and went to the district office in the early part of May 1959. He waited about 1½ hour before the Social Security representative saw him. It seemed to the applicant that the Social Security representative acted as if she doubted the credibility of his story. She told him that if he wanted to file this claim, she would assist him in preparing the necessary applications. Mr. ——— insisted that he was not told how disabled he had to be nor was the disability program fully explained to him. He stated that after the interview with the Social Security representative he felt he could use additional assistance in preparing his claim but did not obtain any because he could not afford to pay. He took the medical forms to his personal physician and the hospital. He was not charged for the preparation of the forms. He remembers receiving a letter from the district office telling him that they did not receive the medical reports from the hospital.

Sometime in August, the State rehabilitation agency, prior to making the disability determination, sent the applicant to a cardiologist. Mr. ——— stated that he received a thorough examination which included an electrocardiogram and a chest X-ray. Dr. ———

treated him like a gentleman during the whole examination. This examination was at no charge to the applicant.

Mr. ——— showed me his denial letter dated September 24, 1959, and pointed out that it had very little explanation of his denial. Mr. ——— stated that his doctor told him he cannot work due to the condition of his back which causes him to have severe dizzy spells and headaches. Mr. ——— stated that he is not and has not worked since December 1957. He also stated that he did not appeal his case because he feels that a person has to be on a death bed to qualify.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I interviewed Mrs. ——— on December 17, 1959. Mrs. ——— lives alone in a neat, small apartment. She has not worked since 1956. Mrs. ——— stated she lives off her savings which are rapidly being depleted. The applicant, age 59, appeared to be in good health although she was quite nervous. The applicant was quite concerned during the interview over her denial of benefits.

Mrs. ——— showed me a letter dated June 19, 1957, from the State unemployment agency which informed her that she was not entitled to unemployment benefits since she was not available for work. Mrs. ——— stated that it was probably through the State unemployment agency that she learned of the disability program. The applicant stated that she had visited the district office on two different occasions and that both times the office was very crowded and that she waited from 30 to 60 minutes before someone talked to her.

Mrs. ——— stated that, although the district office was not discourteous or rude, they could have been a little more understanding. The applicant stated that the district office neither encouraged or discouraged her to file an application, but merely processed it upon her request. She feels that her rights under the disability program and the extent of disability necessary for qualification of benefits were not fully explained to her. When asked if she could expand on this, Mrs. ——— stated that more consideration should be given to a person's ability to work. Mrs. ——— stated that she periodically suffers strokes which stiffen her right arm and left leg and that, to be cured, she must undergo brain surgery which she is frightened of and unable to afford. She also stated that she recently learned that she has cancer.

Mrs. ——— has filed for disability benefits twice in the last 3 years. She stated that in both instances the district office personnel filled out the application while questioning her and then asked her to sign it. The applicant stated that on the two occasions when she filed for benefits she was furnished medical report forms which she had her personal doctor fill out. Mrs. ——— stated that after her first denial letter in December of 1957 she changed doctors and that she cannot remember whether her previous doctor gave her a current medical examination or charged a fee for the preparation of the medical report. In connection with her second application, Mrs. ——— stated that her doctor had given her a current medical examination and charged her for it. With respect to the medical report, Mrs. ———

indicated she furnished the postage stamps for the report but that there was no charge for its preparation. The applicant stated that she felt she did not need additional assistance in preparing her claim after she first talked to the district office.

Mrs. ——— stated that the State vocational rehabilitation agency arranged a medical examination for her. She stated that the doctor gave her a very thorough examination and was very courteous.

Mrs. ——— stated that she was not satisfied with the denial letters she had received, indicating that they were form letters and did not have any pertinent particulars as to why her claim was denied. Mrs. ——— showed me the two denial letters she received dated December 19, 1957, and September 9, 1959; the letters were identical form letters. The applicant stated she has not gone to the district office for further explanation as to why her claim was disallowed. Mrs. ——— stated that she intends to contact the district office after the Christmas holidays.

I thanked her for her cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I interviewed Mr. ——— on December 17, 1959. Mr. ——— was very courteous and cooperative and his answers to our questions showed an understanding of the disability program. He lives in a very tidy apartment house with a 10-year-old daughter. His wife has been in various hospitals for more than a year. At present, she is in a hospital with cerebral atrophy. Mr. ——— stated that his wife will probably never recover from this sickness.

He had applied for public welfare and is presently receiving \$69.20 on the 3d and 18th of every month. He stated that he has a hard time living on this amount. He cannot work at his trade as a dyer and cleaner in a cleaning establishment because the work is too strenuous for his heart.

He stated that he has not been feeling well but as soon as he feels better, he intends to try to get some part-time clerical work. He wants to be home by 3 p.m. when his daughter returns from school. He seemed to be tired, weak, and ill. Mr. ——— also stated that he would like to see the Federal Government set up a medical plan to aid aged people and their families meet the high costs of medical expenses.

Mr. ——— read about the social security disability program in the newspapers. His workmen's compensation office told him the location of his district office and he went there to apply for disability benefits. He waited about 15 minutes before he saw a claims representative. He was treated very courteously and the representative explained the disability program to him. The claims representative encouraged him to file an application.

The Social Security representative helped Mr. ——— fill out his application and then gave him a medical report for his doctor to complete. Mr. ——— took the form to the hospital where it was completed and returned to the Social Security office. He was not examined or charged for the preparation of this medical report. He did not recall taking or mailing a report form to any doctor.

Mr. ——— stated that he was sent to Dr. ——— for an examination. He was well satisfied with the doctor's examination and he assumes that the doctor mailed in a medical report. Mr. ——— had no further comment on his treatment by the district office personnel. He did not feel that he needed more assistance than he had received in preparing his claim.

Mr. ——— was disappointed when he was denied. However, he does not intend to reopen his case. He felt that he was turned down through some technicality in the law and even if he reopened his claim the same technicality would be present. All Mr. ——— wants to do is go back to work on a part-time basis. He stated that he intends to go to the State unemployment office as soon as he is able to do so.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I interviewed this 60-year-old applicant at his home on December 23, 1959. He is a tall, big man and looked healthy. He lives in a large house with his wife. They receive \$150 a month, which is their income, from a State workmen's compensation pension. He told me that he has third degree asthma and has not worked since 1957. He said that he applied for workmen's compensation in October 1958 and his claim was allowed in February 1959.

At the beginning of the interview Mr. ——— said that he did not keep his records concerning his Social Security disability claim and he had a poor memory. However, he agreed to answer the questions. He stated that he heard about the disability program from his friends, some of whom had already applied for disability pension. He said he knew where to go, and applied at the district office sometime in January 1959. He did not wait long and was treated well by the district office representative. He doubted whether the representative adequately described how disabled he had to be to qualify for a disability pension. He said that the representative neither encouraged nor discouraged him to file an application for benefits. The claims representative asked him a number of questions and completed the application for him.

He did not remember if the medical report form was given to him when he filed or if it was mailed to him at a later date. He said that he had not been regularly treated by a family physician prior to filing his claim. He took the medical report to the doctor who had previously X-rayed his chest and who had submitted this as evidence for his workmen's compensation asthma claim. He said that the doctor completed the social security medical report form after giving him an examination. He was charged for the examination but he did not remember if he was charged for the preparation of the medical report. Sometimes later he was notified to visit three doctors who examined him.

He stated that the social security denial was only a form letter and that it did not explain the specific reasons why his claim was denied. He said "I wouldn't feel so bad if I knew why I was turned down." I asked him if he planned to appeal his case. He felt that he did

not want to go through that ordeal again and that he could not afford the cost of hiring a lawyer to represent him. He concluded that he would live on his pension until he became 65 years old then he would automatically qualify for social security benefits.

Mr. ——— did not seem to understand what was meant by "totally disabled" when he applied for disability benefits. He believes that he is unable to work.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I arranged by telephone to interview this 52-year-old applicant on December 21, 1959. The applicant is a retired Army colonel and lives with his wife, a school teacher, and two teenage sons. The colonel receives \$600 a month from the Army.

The colonel is suffering from arteriosclerosis and held his leg in apparent pain while shifting his weight in the chair during the course of the interview. He stated that he has been hospitalized approximately 62 weeks in the last several years and is currently participating in a 5-year Veterans' Administration research study on arteriosclerosis. The applicant took considerable time in elaborating on his answers to my questions and talked on various subjects during the 2½-hour interview.

The colonel learned of the disability program from an Army publication. The colonel visited the local district office after learning of its location from the telephone directory. He stated that the office was very small and that he was waited on promptly.

The applicant stated he had always felt a sort of repugnance toward relief and social welfare programs and only visited the district office in an effort to have his wage record frozen. The colonel stated he was not interested in the current income from disability benefits but hoped to protect any benefits due his wife and children as survivors in the event of his death.

The applicant feels that the district office representative was not discourteous but could certainly learn something in the field of public relations. He stated he was very embarrassed by the district office representative's lengthy discourse on the penalties of perjury and by other challenging remarks regarding the extent of disability required for benefits. He stated the district office representative cautioned him that disability determinations under the Social Security Act were made under different criteria than those of private insurance companies and other Government agencies without ever describing how disabled a person had to be to qualify. The colonel feels that more consideration should be given to applicants whose general appearance is not indicative of their real condition.

The applicant was denied benefits and later filed again for disability benefits. He stated he refiled for benefits at the suggestion of a Veterans' Administration representative who talked to him during one of his periods of hospitalization at the hospital. The colonel had no criticisms stemming from his later dealings with the Social Security district office. He stated he dealt with a young woman who

was very courteous and a credit to the Social Security Administration.

The district office representatives on both occasions filled out the colonel's application while questioning him and then gave it to him to sign. The applicant stated he did not receive any medical report forms for his doctor to submit but signed a statement instructing the hospital from which he had received treatment to release medical history on his case to the Social Security Administration. The colonel also called upon his attending physician, who submitted medical evidence of his disability without making a current examination or charging him for the submission of the information.

The colonel did not feel he needed additional assistance in preparing his claim. However, he questioned the necessity of all the information about the disability program that is promulgated to the public. The colonel feels that publications, newspaper articles, and radio announcements pertaining to the disability program give false or misleading information regarding the conditions under which disability benefits are paid and unnecessarily raise the hopes of needy and aged people.

The applicant stated he was not satisfied with the denial letters he received, indicating that the reasons given for denying his claim were too "skimpy." The colonel sought no further explanation for his latest denial because he stated he is not that interested in receiving benefits and would not want a recurrence of the circumstances under which he received his two previous denial letters. He stated that both times he received the denial letters he read them through an oxygen tent in the hospital.

The colonel feels that the disability program should provide a freeze period for temporary crippling sicknesses which may prevent a person from seeking employment for several years. He also believes that consideration should be given under the present program to employers' hesitancy to hire an individual with a disability which may not necessarily make him a "basket case."

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I interviewed Mr. ——— on December 28, 1959. He was not completely clothed, had on a ragged summer shirt, no socks, torn trousers and shoes not his size with the soles full of holes. He said he had worked for a bag company for 6 years prior to 1951, about 6 months for a railroad, and since 1957 has been trying farm labor jobs, such as corn picking, when able. He has no income from any source except these farm jobs in the summer.

Mr. ——— said he heard about the disability program through general information and filed his application at the contact station, where a Social Security representative comes each Tuesday. He stated he was treated "pretty good" at the Social Security office but waited about two hours to see the representative. He asserted the only part of the program or his rights explained to him was about filling out the application, and that he had to be disabled "so he couldn't work". He said he was not influenced to file or not to file.

The Social Security representative prepared the application form for Mr. ——— and gave him the medical report form which he took to his doctor. He said the doctor charged him \$3 for the examination but nothing for preparation of the report form. He did not know of any other reports obtained by the Social Security office. He did not feel he needed any additional assistance, as he was told all he had to do was sign the application, and he did not seek outside aid. He had no other comments on his treatment by the Social Security representative.

As to the letter denying his application, the applicant said he was not real sure his claim was denied but took no action because he was not sure of what could be done since he did not have any rights explained to him when he had filed his application. He said he had not heard of reconsideration, referee's hearing, Appeals Council, U.S. Court, or legal representation. Moreover he said he has reached the end of the line, no health, no money and can't even get medicine which might help. He also said he had no plans for the future with regard to the program or his case.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I kept an appointment with Mrs. ——— on December 22, 1959. The applicant and her husband were both present at the interview.

Mrs. ——— stated that she found out about the disability program from two sources, the newspaper, and several life insurance men. She knew the location of the district office herself and she went there several times. In all her transactions with the district office, she said, she did not have to wait long before someone talked to her and she was treated courteously at all times. The applicant stated that on her first call the receptionist, after finding out that she was inquiring about getting disability benefits, made an impertinent remark. The remark quoted by the applicant was: "You look as though you are able to work."

The applicant stated her belief that the program had been explained quite thoroughly but she said she did not understand completely about not being able to do any kind of work. She said that if she had been fully aware of the requirement she doubts that she would have submitted the application. Mrs. ——— would not say if she was either discouraged or encouraged to file an application. She did say that she was left with the impression that everything depended on her physical examination.

The applicant said that the office helped her in filling out her application. She said the questions about her physical condition seemed proper and clear. She said that a representative asked her, "Is your husband working?" She wondered about the reason for the question.

She got her medical proofs from her family doctor, who made no charge for completing the medical report and from another doctor, to whom the district office sent her, who said he would bill Social Security for his services. After the applicant first talked to the district office, she did not feel the need for any other assistance in preparing her claim. She neither asked for nor received any assistance from any other source.

The applicant never returned to the district office to make further inquiry after she received the denial letter and read the reason for denial and the other actions open to her. She said that she concluded "so far as my case is concerned that's the end of it."

Mrs. ——— said that her own family doctor says that she should not work at all because she tires too easily but that the Social Security doctor said she could work. The applicant has done no work since March 1950. She was uncertain, and did not commit herself, about the possibility of filing again in 6 months and about getting additional evidence. I believe the applicant fully understands the conditions set forth in the denial letter.

At the end of the interview Mr. ——— made the following remark, although not in anger, "You would think people were after some kind of charity when you go to a Social Security office; when all you want is to find out how you stand there."

I thanked them for their cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I arranged by mail to interview this 58-year-old applicant on December 28, 1959. He lives on the second floor of an old three-family house. Mr. ——— stated that he has no income and his friends have helped to support him. He also mentioned that he owes a few months' past due rent and the landlord may evict him at any time. He can no longer work as a laborer because he has been disabled by osteoarthritis of the spine. He cooperated fully.

Mr. ——— found out about the disability program from a social security booklet which he obtained at his district office and subsequently returned there to file a claim. He stated that district office personnel had treated him courteously giving prompt attention to his claim. However, the Social Security representative did not explain the disability program nor did he describe how disabled he had to be in order to qualify for benefits. The representative did not encourage or discourage him from filing the application. Mr. ——— had already decided to file before he went to the district office.

The Social Security representative filled out his application for him. He took the medical report form to his doctor, who gave him a medical examination at this time. The doctor charged him for the examination but did not make a charge for the preparation of the medical report. Mr. ——— stated that he did not mail or take a medical report to any other doctor.

The State rehabilitation agency had the applicant examined. Mr. ——— stated that the doctor gave him a good examination. He was not charged for the examination; he believes that the doctor sent a medical report to the State rehabilitation agency.

Mr. ——— felt that he needed additional assistance in preparing his claim. He made no other general comment about the treatment he received at the district office.

Mr. ——— was not satisfied with the explanation for the denial action. He felt that because he was unable to work, he should receive a disability benefit. If he decides to appeal the denial he probably will do so in January. Mr. ——— is not working.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I interviewed this 59-year-old applicant at his home. He lives alone in a ground floor, rear, one-room apartment in a slum section of the city. The apartment was neat and tidy but shabbily furnished. The applicant appeared healthy. He answered all questions fully and frankly. I believe his answers were credible.

Mr. ——— has been on public welfare since 1951. He receives \$33.50 every 2 weeks. In 1951, doctors found he had diabetes and he has been taking insulin ever since. He said that his employment terminated in 1951 because he could not work and that the doctors said he should not try to work.

He stated that public welfare found him a job in a hospital kitchen in 1955 or 1956. But after he was given medical examination by its doctors, which confirmed that he had diabetes, he was fired.

The applicant stated that public welfare sends a social worker to call on him about three times each month. In 1957 public welfare obtained letters from two hospitals where he had previously been employed and a letter from a personal doctor describing the applicant's physical condition. He said that in 1958, on this basis public welfare urged him to get treatment, found that he couldn't work, and suggested that he go to Social Security about disability benefits.

He went to the Social Security district office. Mr. ——— stated that the people in the district office treated him courteously and without delay, explained the "rules" of the program and his rights under the program, explained how disabled you have to be to qualify and answered all his questions. They let him make up his own mind whether or not to file. The Social Security representative did not assist the applicant in filling the application form. She gave him an application to fill in himself at home.

On the applicant's second visit medical forms were given to him to mail to the two hospitals and to take to his family doctor. Later, the applicant was told that additional medical information was needed and he was given another medical form to take to a different doctor. He said that this doctor gave him a complete examination. The applicant said he had never at any time, paid for any medical examination.

He said that he had received no advice or assistance from any other source. The applicant stated to me that he had only a fourth-grade education and that he had considerable difficulty with the forms he had to fill in and sign. However, he mentioned that he completed the "paperwork" all right but what had troubled him most was the carefare and the pain in getting around.

Next, he received a denial letter dated September 28, 1959. I asked the applicant if he had requested further explanation at the district office and if he knew what his rights were under the program. He said he believed that after all the examinations by the different doctors, if they didn't know he couldn't get around and work, there was nothing he could do about it. He said that he supposed Social Security had enough information to know that he could not work; besides he cannot afford to pay for additional medical evidence. Mr.

——— stated that he is going to revisit the district office and ask them what he can do to convince them that he cannot work.

He again brought up the matter of public welfare. He said "Doesn't anybody believe that a man would work if he is able and if he could find any kind of work rather than try to live on \$33.50 for 2 weeks?"

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I made an appointment by telephone to see Mr. ——— on December 28, 1959. He lives with his wife in a three-room apartment in his son-in-law's house. Mr. and Mrs. ——— were present during the interview. They stated that their son-in-law had the apartment made especially for them. Mr. ——— mentioned that he will be 65 in June and he will then file for old-age benefits. He stated that after he reaches 65 he will not have to worry about disability benefits any longer. At the present time he is receiving a veteran's non-service-connected disability pension of \$66.15 a month. He stated that he was a bartender but that he is physically unable to work at his trade because he cannot stand on his feet very long. Mr. and Mrs. ——— seemed sincere and were cooperative in their responses to our questions.

Mr. ——— first heard about the disability program from a friend. He knew the location of his district office, so he went there to learn more about the program. He was treated courteously after waiting about 15 minutes for a Social Security representative to discuss his case with him. The representative did not fully explain the disability program to him nor did he describe how disabled he had to be to qualify for benefits. The representative did not encourage or discourage him but rather permitted him to personally decide whether to file a claim or not. He filed an application on his second visit to the district office.

The representative filled out the application for him and he subsequently took the medical report form to his doctor's office on one of his regular visits. Dr. ——— examined him before preparing the report. He was charged for the examination, but not for the preparation of the medical report. He doesn't recall mailing or taking a report to any other doctor.

The State rehabilitation agency sent Mr. ——— to Dr. ——— for an examination. He was not satisfied with the examination. He stated that he waited 3 weeks for the appointment and then when he finally went to the doctor's office, he had to wait more than 1½ hours before seeing him. He stated that the doctor was courteous but he did not give him a satisfactory examination. He stated that the whole examination was oral and took about 2 minutes.

Mr. ——— felt that he needed additional assistance in preparing his claim after his initial visit to the district office and that he obtained such assistance from the Veterans' Administration. He made no further comment about his treatment by Social Security.

Mr. ——— was not satisfied that the letter he received explaining the denial action was sufficient. He could not understand how the decision to deny benefits was reached, however, he does not intend to

reopen his claim because he will be 65 in June and will file for old-age benefits. Mr. ——— is presently working and is paid \$1 an hour. He works approximately 30 hours a week.

I thanked them for their cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I kept an appointment with the applicant on December 30, 1959. Mrs. ——— is 56 years old and lives with her husband in a neat tenement apartment. She appeared to answer all questions completely and frankly. The applicant has not worked since 1956. She said she knew about the disability benefits in the social security program because she had read about it in the newspapers.

Mrs. ——— stated that the doctors told her that she had an enlarged heart, and high blood pressure. She now has some difficulty in getting about at home without a cane. She is able to do light housekeeping in her home but she said that this work causes her to have headaches so severe that she has to take sleeping pills to get her rest.

Mrs. ——— felt that she should get disability benefits because she knew that she could not work, and because the hospital had suggested that she file a claim with Social Security. She said that after paying social security taxes for many years she believed there would not be much doubt about her right to benefits. She stated that she had worked at pressing and other laundry jobs and she had to stand most of the time. She said that she could not possibly do this work again and she was not trained for any other kind.

The applicant said that on her visit to the district office she had been treated courteously but the representative had not given her much explanation concerning her rights under the program or how disabled she must be to qualify for benefits. The girl at the district office helped her complete the application. The applicant said that she had never felt it necessary to get outside assistance in preparing her claim and that she had received no help from outside sources. She said that she had never been charged a fee for any medical services. The applicant stated that the representative told her the district office would get all the necessary medical reports from the hospital.

She stated that she had read the denial letter carefully and believed that she understood it. She was not satisfied as to the reason her claim had not been approved. The applicant said that since she received the denial letter she had not taken any further action. Mrs. ——— believed that it would be useless for her to seek reconsideration of her claim.

I thanked her for her cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I kept an appointment with the applicant on January 5, 1960. She is age 60, and has been working as a waitress since Social Security denied her claim in September 1959. She lives alone in a small apartment which costs \$12 per week.

The applicant said that her work requires her to stand about 9 hours a day and that at the end of her 3-day week she is extremely nervous and physically exhausted. Her own family physician has told her repeatedly that she should not do such work. She stated that her doctor had indicated on the social security medical form that she was not physically fit to do work of any kind. Miss —— stated that since 1956 she has been in three hospitals.

Miss —— stated that she learned about the disability program from newspapers but did nothing about it until she applied for unemployment insurance. She said that she was told she was not eligible for such insurance but she was sent to the Social Security office to ask if she could qualify for disability benefits.

She said that she was treated courteously; she did not have to wait for attention; and she was given a good explanation of the program. However, she said that the district office did not fully explain how disabled she must be to qualify but she was left with the idea that she would have to be chronically ill, that is, permanently and totally disabled. She said she fully expected to be paid disability benefits because her doctor had been telling her that she was seriously ill and should not do any laborious work.

The district office neither discouraged nor encouraged her to file for benefits. She decided herself about filing a claim. The applicant said that the district office helped her complete the application and other forms.

Miss —— said that the district office gave her two medical forms. She took both forms to her doctor and he examined her, filled in one form and said that he would take care of the other form by contacting the various hospitals which had treated her during the past several years. The applicant said that her doctor charged her for an office visit but made no charge for the medical report and examination. The applicant stated that she did not need additional assistance to process her claim. She said that she had received no help from any other organization.

Miss —— stated that after receiving the denial letter she talked to her doctor about it and he again advised her not to do any kind of sustained work. She said she decided to work and that she would "stick it out as long as she could."

She knew that she could appeal her denial. Nevertheless, she said she would not do anything further unless told to by her doctor. She believed that she could not stand any additional nervous upset because her health is steadily getting worse.

She said she cannot afford to have anyone represent her at a hearing because she has no money above the cost of room and board and medicine; and she cannot afford to lose time from work. She said that her pay is \$4 per day plus tips estimated at \$6 per day. She has no other income. This applicant seemed compelled by extreme hardship to work despite her physical inability to do so. She stated, "I never expect to live until I'm 62 and can get any regular social security benefits."

I thanked her for her cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

Mrs. ——— was interviewed on December 28, 1959, where she lives in a small third floor apartment. She appeared to be healthy and mentally alert and was able to walk around the house unassisted. She is a diabetic.

The applicant said she learned about the disability program through the newspapers and that her daughter told her to go to the Social Security district office. She was treated courteously at the Social Security district office.

The applicant said that she did not have to wait long before someone explained the disability program and her rights under it. She said the Social Security representative did not explain to her how disabled she would have to be to qualify. The applicant said the Social Security representative neither encouraged nor discouraged her from filing an application but gave her information so she could decide herself whether to file. He gave her the necessary forms. She obtained her medical proofs from her doctor to whom she had taken a medical report form. The doctor did not charge for the preparation of the report or for the medical examination he performed at the time.

Mrs. ——— said she gave another doctor a medical form but that she did not recall his name. In addition, the State agency required her to be examined by a doctor they designated. The applicant said she did need assistance after she first talked to the district office but that she did not get any from any source. She said she had no general comments to make about her treatment by the district office. The denial of benefits was satisfactorily explained in a letter from the Social Security, therefore, she did not take any further action. The applicant said the district office explained to her that she was not disabled enough to qualify and that she understood this. Mrs. ——— said she was told she could appeal her case but does not recall whether she was informed that she could submit additional medical evidence. She said she did not request a hearing.

Mrs. ——— said that she is not working at the present time.

I thanked her for her cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I interviewed Mr. ——— at his home on December 29, 1959. He is a 58-year-old, short, stout man with a ruddy complexion. He lives in a small attractive cottage with his wife. Mr. ——— has degenerative osteoarthritis of the left hip. Except for this impairment he looked healthy. When he moved about during the interview he walked slowly with a noticeable limp and held onto fixed objects for support. On several occasions his facial expressions showed signs of distress and pain. He said that he had constant pain and that the only time he was relieved was when he was lying in bed. He said that he could not move without severe pain and that this greatly limited his activity. In fact he complained of pain during the interview.

He stated that he was employed as a machinist until December 1958 and that he has been unable to work since then. He said that now he has no income and that he and his wife are living on their savings.

Mr. ——— said that he had been regularly treated by a doctor who in May 1959 recommended that he have an X-ray taken. In June 1959 after reviewing the X-ray and after a thorough physical examination the doctor informed Mr. ——— that he had degenerative osteoarthritis which would progressively worsen and advised him to apply for social security. Mr. ——— said he had learned about the disability program from reading the newspaper.

After telephoning the unemployment bureau to ask the location of the nearest Social Security district office he went to the district office and filed an application for disability. He said that he did not have to wait long and was treated courteously. However, he said that the disability program and his rights under the program were not explained to him. He added that he received no information about how disabled he had to be to qualify for disability pension. He said that shortly after he filed his application he purchased a home law book and it has been his main source of information about the disability requirements and the rights under the program.

The district office representative asked him questions and filled out the application. The representative gave him a blank medical report form which he took to his doctor. He was not examined at the time the doctor filled out the report and was not charged for its preparation. The doctor also submitted the report of X-ray. In August 1959 Mr. ——— was notified to go to an orthopedic specialist for an examination. Mr. ——— said that all the doctor did was put pressure on his hip from various positions. He said that he was stiff and had extreme pain for 2 days after the examination. He stated that to the best of his knowledge his doctor's medical report, the report of X-ray and the specialist's report were the only medical proofs submitted for his claim. He felt that he needed no additional assistance with this claim. He received no assistance from other persons or organizations.

He said he was not satisfied as to the reason his claim was denied. He said "I can't see how Social Security made this decision especially since my doctor tells me that I am unable to work. It just doesn't add up." He said "I have pain all the time and if I do any type of work my hip becomes so sore that I am hardly able to move about." Mr. ——— was aware of his rights of appeal. He stated that he had read about them in the denial letter. Mr. ——— very disgustedly said "I've done everything that I can do. I don't see how I'm going to convince them that I cannot work." He said that he planned no further action and exclaimed that "If Uncle Sam thinks that I'm not eligible for disability benefits then there is nothing I can do. Who am I to fight the U.S. Government?" He steadfastly maintained that he would not "bring action against the Government." He said that he had never tried to deceive the Government in his life but that the denial letter made him feel as if Social Security thought he was trying to "pull a fast one." He stated that for the past 5 years his wife had been working periodically, mostly during the Christmas season. He said that a year ago his wife was informed that she could apply for unemployment compensation at the conclusion of her seasonal

work. Mr. ——— regarded this as improper and refused to let his wife apply for such compensation.

Mr. ——— felt that there were certain inequities in the social security program. He mentioned that widows, who are physically capable of working, automatically receive social security benefits when they are 62 years old. Yet, a man such as himself must be practically dead to qualify for disability benefits. He also mentioned that widows with children in their care were hiring day nurses and babysitters to tend to their children while they go out on-the-town enjoying themselves.

He felt that these widows were benefiting for something they were failing to do. He said that a man who paid into the trust fund from the beginning of social security and who was advised by his doctor to cease working must be subjected to all kinds of examinations and then turned down. He stated that although Social Security turned him down his doctor still maintained that he should not work. He said "I just don't understand it."

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I met with this 52-year-old applicant in his home on December 28, 1959. Mr. ——— is unemployed and lives with his wife and two grown children in a wooden structure which was originally intended to be a machine shop. Mr. ——— related a series of physical mishaps which had befallen him since 1938. They included a back injury incurred as a labor foreman in 1938 and injuries to his legs resulting from being struck by an automobile in 1950. Mr. ———, a rather solidly built, 280-pound man, has the physical appearance of a healthy person. He stated that, because of the repeated mishaps that have befallen him, he felt several years ago that he was destined for a mental institution and, until recently, has had difficulty remembering past events and thinking clearly. I believe the applicant's comments while being somewhat questionable were nevertheless sincere.

The applicant stated he learned about the disability program from a clinic, where he had received treatment. He showed me a circular from the clinic informing him of the location of the Social Security district office. The applicant stated he visited the district office approximately six times and never was treated discourteously or had to wait long before someone talked to him. He stated that he received a full explanation of the disability program and his rights under it and also received pamphlets regarding the program. The applicant cannot recall the district office representative describing how disabled a person had to be to qualify for benefits. He feels he was neither encouraged nor discouraged from filing during his visits to the district office; however, on one of his later visits, he stated a woman employee asked him why he kept coming back.

The applicant cannot recall what assistance he received in filling out his application but stated he signed a statement indicating that he was willing to work at some type of employment that would not aggravate his condition. He showed me several letters from the dis-

district office in response to telephone inquiries made by him and stated that the district office mailed him medical report forms for his doctor to fill out. Mr. ——— stated he had considerable trouble getting doctors to fill out the medical report forms furnished by the district office and feels that this is due to the fact that someone from the district office preceded his visits to various doctors and discouraged them from filling out the reports and informed them to disregard his requests. He stated he had to make four requests at the clinic before the doctor finally submitted the required report.

The applicant went to a Dr. ——— and requested a general examination. The doctor put him in a hospital for observation. Mr. ——— stated that, prior to his release from the hospital, he requested Dr. ——— to furnish medical reports regarding his disability claim and that this doctor also was reluctant to furnish such reports and only at Mr. ———'s insistence were they finally submitted.

Mr. ——— stated he could not understand the reluctance of doctors to fill out the medical report forms because they are just required to submit medical data on the applicant's condition. The applicant stated he knows of no other medical reports from doctors or hospitals that were obtained or submitted in his case.

Mr. ——— stated that Dr. ——— did not give him a current examination at the time of submitting the applicant's medical report and did not charge him for the preparation thereof. The medical report submitted by Dr. ——— was based on the doctor's findings at the time the applicant was hospitalized and the applicant stated he is not aware of any special charges in relation to the required medical report.

The applicant stated that, after first talking to the district office, he did not feel he needed any additional assistance in preparing his claim. However, he stated that the district office representative asked him if he had an organization which could help him in processing his case and he feels that this question was asked by the district office to determine what their action would be in processing his case.

Mr. ——— was not satisfied with the reason given for denying his claim in the letter he received. He stated he is planning to go back to the district office after the first of the year when he feels better.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied—No Appeal Made

I kept an appointment with Mr. ——— on January 12, 1960. This 62-year-old applicant lives with his wife in a small motel-like apartment development which he owns and operates with help hired to do the physical work. His wife is unable to assist him in the apartment operation. In 1956, Mr. ——— had a small but very successful grocery business and adjacent rental property. He suffered swollen ankles and had to quit the grocery business. He began the apartment operation in May 1959.

Mr. ——— said that in February 1959 he suffered a heart attack and called a doctor. The ailment was diagnosed as hardening of the arteries. Excitement or active exertion causes severe pain in the heart

region. The doctor forbade the claimant to make any sustained physical effort and prescribed pills to be taken when an attack threatened. Since the onset of his ailment Mr. ——— consulted two other local physicians. The applicant stated that these three doctors all concurred on the diagnosis of his condition and ordered him to avoid any excitement or any regular work of any kind because at any time the severe angina might set in. The applicant showed me three bottles of pills which he carries with him at all times. Mr. ——— said that when he takes one of these pills it sets up a very severe headache which he has to relieve by taking another type of pill. The applicant appeared upset, tensed up, and excited even while he was sitting down. He said repeatedly that he wondered how it was that the three doctors who had examined him all agreed that he should not and really could not work while another doctor who examined him for the Social Security agency said he could work. The applicant said repeatedly that he was positive he should not work because when he tried to work he experienced breathlessness and exhaustion of the kind that had preceded his first actual attack in February 1956.

Mr. ——— stated his belief that it was the doctor who examined him for the Social Security agency who had insisted, after examining him, that he was able to do gainful work. The applicant said that before and after the examination the doctor requested him to sit perfectly still for about 15 minutes. The applicant then became very insistent on the absurdity of the denial decision. He said, "How could it be possible for me to rest before and after every effort I might make, either in my own business or while working for someone else?" He further said, "Who would possibly hire a man in such condition that a physical effort might throw him into a heart attack?" Mr. ——— followed up these remarks by "Do they know that I was turned down for Blue Cross insurance because I'm considered too far disabled for them to cover me?"

Mr. ——— said that he had first learned about the social security disability program in 1957 when he had taken an elderly aunt to the district office. At that visit, he said he had picked up a public relations pamphlet and read it. He said that he went only once to a district office and that visit was very soon after his heart attack. He said that he was treated courteously and promptly. He stated that not nearly enough explanation had been given to him about his rights under the program or about how disabled he would have to be to qualify. He stated that because he had a long interview and had answered a lot of questions in order for the representative to fill out the various papers he had felt that everything would probably go through without much difficulty. He said that he felt this way because he already knew from medical information from his own doctors how seriously he was disabled.

He was neither discouraged nor encouraged to file by the district office and he made up his own mind to file. He said he was given three medical reports, two forms for his two personal physicians and one form for the "Social Security doctor." He said that none of these doctors made a charge either for preparing the forms or for examining him. He said that he had received no assistance from any other organization. He said his treatment by the district office was "good."

Mr. ——— was not satisfied as to the reason his claim had been denied. He understood the contents of the denial letter. He said that he had not yet inquired about it at the district office nor consulted anyone else. He said, however, that he had informed his personal family doctors and that they both were surprised that he was denied disability benefits. He said he would write a letter to the manager of the district office.

Mr. ——— said that he would also write a long letter to his Congressman explaining his great dissatisfaction with the action of Social Security in denying his claim because they thought he was able to do gainful work. He said that the decision was unrealistic and arbitrary considering what his doctors had told him and what he felt about his own condition.

Mr. ——— asked "How can Social Security compel a person to work when all his doctors warn him that work might be very dangerous and make his condition worse or even fatal?" He followed this by, "I'm lucky because I won't starve if I don't get the benefits but I'm wondering how people who haven't enough to support themselves manage to work if they are permanently and totally disabled." Mr. ——— said that he is barely making a living from his apartment property.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied—No Appeal Made

I interviewed this applicant at his home on December 21, 1959. He lives with his wife and son in one-half of a duplex which is half-way up a long, steep hill. The house was badly in need of repairs and paint. The condition of the household furnishings indicated that these people were experiencing a prolonged financial hardship. Mr. ——— is a small, frail-looking person who appeared to have suffered prolonged illness. He said that he has had a serious heart condition for over 6 years. He filed two separate applications for social security disability benefits and was denied both times. He stated that he has sought these benefits for approximately 2½ years. He felt that he was "just about to the end of the rope." He said that he gave Social Security all the information they wanted but that it seemed to take an eternity to get a decision. His wife said that they were bewildered and did not know what to do next.

He worked for a coal company when he became very ill and unable to work. He has not worked since 1954. In October 1955, he had a severe heart attack and was hospitalized for a long time. He stated that except for a period of about 18 months when his wife worked they have been receiving public welfare aid. They are now receiving \$116 a month plus medical care and medicines.

It was part of his duties as vice chairman of the local United Mine Workers to advise disabled members about such programs as workmen's compensation and social security. In April 1957, he went to the district office and filed his first application. He said that he waited about 15 minutes before a claims representative talked to him. He believes that the disability program, his rights under it, and the disability requirements were adequately explained to him. He

seemed to have a good working knowledge of social security. He said that the representative was very courteous and that after he explained his physical condition the representative encouraged him to file a disability application.

The claims representative asked him a number of questions and completed the application. He was given a medical report form. Mr. ——— took the form to a doctor who completed it without examining him. The doctor did not charge him for the preparation of the report. He said that he gave the representative written permission to obtain medical evidence from the hospital.

He said that he did not receive any further information on his claim from social security for 11 months. He and his wife called the district office several times and each time they were advised that his claim was being reviewed by the State vocational rehabilitation agency. He showed me a letter, dated March 26, 1958, from the State vocational rehabilitation agency notifying him to go to a heart specialist. He was examined by the doctor. Mr. ——— said he did not feel that he needed additional assistance in preparing his claim and did not receive assistance from other persons or organizations. He was treated courteously at the district office.

He received his first denial letter in either October or November 1958 about 18 months after he filed his application. He said that he read the letter several times and could not understand the reason for his denial. He had felt sure that his claim would be allowed. He called his doctor and discussed the letter with him. The doctor advised him to discuss it with the Social Security people. The representative did not know the reason the claim was denied but suggested that he file a new claim after 6 months.

In March or April 1959, he filed his second application and went through the same procedure as before. He did not submit additional medical evidence with his second application. A letter dated July 7, 1959, from the State vocational rehabilitation agency again referred him to the same heart specialist. He was given the same type examination.

Mr. ——— received his second denial letter on September 3, 1959. He was quite upset about it. He stated that he has been advised by his doctor to avoid activity which will cause him to become tired, such as walking up and down steps and excessive bending and lifting. He said "I'm a prisoner within my own home, yet I'm not eligible for disability benefits." He explained that his movements around the house are further restricted because he lives on a steep hill and cannot go for walks. He said he was told (either by the doctor or the claims representative) that he could "sell newspapers on the corner." He argued that to do this work he would have to be transported by vehicles to and from the corner everyday, be subjected to extreme weather, and probably have to work long hours. Besides, he doubted whether such a job would be obtainable by a man in his condition.

He said that he was aware of his right to appeal his claim but was still undecided about any future action. He seemed to have given up all hope of getting disability benefits and felt that he probably would not appeal.

I thanked them for their cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I kept an appointment with Mrs. ——— at her home on December 31, 1959. Mrs. ———, who will be 51 years old in February 1960, is a widow and lives alone in a small cottage in a rural area. She appeared in good health and had no obvious physical impairments.

She said that a neighbor suggested that she apply for social security benefits. She made up her mind that as soon as she could drive she would go to the district office and file an application.

On July 15, 1959, she went to the district office and filed for disability benefits. She knew where to go because she previously filed for her husband's death benefits at that office. She did not wait long at the district office and was treated courteously by the employees. At the time she filed her claim she was planning to return to work. She believed that she was filing for benefits for the 8-month convalescent period. She did not know that her disability had to be permanent and her thinking was not clarified until she received the letter of denial. She said that if the representative had explained the program she would have known immediately that she was ineligible. The claims representative merely asked her some questions and completed the application. She was given a medical report form which she left with her doctor's secretary. She explained that the doctor had no prior knowledge that she had applied for disability benefits. He submitted the report without requiring an examination and did not charge her for preparing the form. She said that the failure of the claims representative to explain the program requirements had caused her unnecessary embarrassment.

She said that she understood the reason her claim was denied and she was satisfied with the decision. She did not contact the Social Security district office.

A representative from the State vocational rehabilitation agency contacted her to determine if they could assist her in obtaining work. She informed him that she had returned to her former job. She is a sewing machine operator and earns about \$56 a week.

I thanked her for her cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I interviewed Mr. ——— on December 16, 1959. The applicant lives alone in a furnished room. Mr. ——— stated that he could not understand why he was denied disability benefits because the State vocational rehabilitation agency declared him unemployable. He is currently receiving social security benefits in the amount of \$49 a month. His correct age is 69 instead of 63 as shown on his application for disability benefits. He had used the fictitious age because he felt this would help him get employment. He has submitted proof of his correct age to Social Security. Mr. ——— also receives welfare aid in the amount of \$14.90 on the 3d and 18th of each month. He was employed as a waiter before he became disabled. I found him to be courteous and cooperative.

Mr. ——— found out about the disability program from the welfare department. They also directed him to his local Social Security district office. He went to his district office where he waited about 15 minutes before speaking to an office representative. He was treated courteously. The representative explained the disability program and his rights under it to Mr. ———. However, he was not sure the representative described how disabled he had to be to qualify. The district office people encouraged him to file an application for disability benefits.

The desk clerk and a representative filled out portions of his application. The claimant mailed the medical report forms to the hospital and to his doctor. He was not charged for the preparation of these reports nor was he examined. He did not mail a report form to any other doctor. He believes that the hospital sent his medical record to the district office.

The State agency recommended that he be examined by another doctor. He was satisfied with the examination and believes that Dr. ——— sent in a medical report which was considered prior to denial of his application.

He had no other comments to make about service provided by the district office.

Mr. ——— was not satisfied with the letter he received from Social Security explaining why his claim was denied. He felt that since he was unable to work he should receive disability benefits. He feels that he is entitled to both old-age and disability benefits. Although I stated he would not be entitled to both simultaneously, the applicant intends to appeal his case within the next few weeks. He is not working.

I thanked him for his cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

I telephoned Mr. ——— and made an appointment for December 15, 1959.

Mr. ——— lives in a small neat apartment. He limped and was very unsteady while standing. He stated that he had arthritis in both feet. He was a very pleasant person to talk to and was very courteous and cooperative in answering my questions. He had been a taxi driver but cannot work at the present time. He has applied for welfare aid and he now receives \$51 on the 3d and 18th of each month.

Mr. ——— learned of the disability program through the department of welfare which recommended that he contact his Social Security district office. He did and was treated courteously. He waited about 15 minutes to see a representative; at that time, the disability program and his rights were fully explained. Mr. ——— was encouraged to file an application.

The claims representative helped Mr. ——— fill out his application. Subsequently, the applicant requested two hospitals to complete medical reports. A medical examination was not made, nor was a charge made for the preparation of the medical reports.

Mr. ——— stated that he was sent to a doctor for a medical examination prior to a denial of his application. He was pleased with the

doctor and the examination. He believes that the doctor sent in a medical report on his physical condition. Mr. ——— felt that he needed no further assistance in preparing his claim other than that he had received from the district office. He also felt that he was well treated by the Social Security district office.

The applicant was not satisfied with the explanation given in the denial letter he received from Social Security. The applicant did not again contact the district office. He does not intend to appeal his case because he is receiving welfare aid. He felt that he would not gain additional money by appealing his case. He did state that he would file for old-age benefits when and if he reaches 65.

I thanked him for his courteous cooperation.

INTERVIEW REPORT

Denied Applicant—No Appeal Made

Dr. ——— was interviewed in his apartment on December 18, 1959. He said that in 1958 he was struck on the head by a truck and sustained a mild brain concussion and was hospitalized for 1 week. The doctor appeared healthy but seemed to breathe with some difficulty. He lives with his wife and two daughters.

Dr. ——— said he read about the disability program somewhere and went to the district office. He said he was treated courteously by the people in the Social Security district office. The claimant said he had to wait some time at the district office. The disability program and his rights were fully explained to him. The district office representative informed him that he would have to be totally disabled to qualify.

Dr. ——— said the Social Security representative encouraged him to file an application. Describing the help he received from the district office, he said they gave him the application form and helped him prepare his claim. The applicant said he obtained his medical proofs from his doctor. He took the medical report form to the doctor. No charge was made by the doctor for its preparation. The applicant said his doctor examined him at this time and charged him for the examination. He did not take or mail the report to other doctors. Dr. ——— said the district office also obtained a medical report from another doctor. The applicant said he did not feel that he needed additional assistance in preparing his initial claim. He said he had no other comment to make about his treatment by the Social Security district office.

Dr. ——— said that he had not yet requested a hearing or talked to the Social Security representative but that he intended to do so. He said he did part-time work for 5 weeks prior to December 11, 1959 at an old-age home.

I thanked him for his cooperation.

APPLICANTS DENIED AFTER HEARING

INTERVIEW REPORT

Applicant Denied After Hearing

I interviewed this 63-year-old applicant at his residence on December 14, 1959. He lives by himself in a three-room apartment on the

ground floor of a nice brick cottage. Mr. ——— stated that he hires a woman to clean his apartment once a week and his married daughter occasionally tidies up his place. He is a very pleasant person without any outward signs of a physical disability.

Mr. ——— is currently working at \$60 per week. His hours of work are from 7 a.m. to 4:30 p.m. He has been on this job since July 6, 1959. Mr. ——— stated that he has a chronic heart condition and was working because of hardship and necessity. He stated that his present employment is at times too strenuous and he carries his glycerin pills with him all the time.

The applicant stated that all the people he contacted at the Social Security office treated him very courteously, and they were so helpful that at no time did he feel that he needed additional assistance from other persons or organizations in preparing his claim.

Mr. ——— stated that he found out about the disability program from the American Legion. He waited less than 45 minutes before the Social Security representative saw him when he visited the district office. The representative encouraged and assisted him in filing the necessary applications. The disability program was not fully explained to him nor was he told how disabled he had to be to qualify for benefits. Mr. ——— stated that he presented photostatic copies of letters and reports he had received from two doctors and a hospital. Current reports were obtained from the same medical sources and also from another hospital.

Mr. ——— was not satisfied with the denial letter dated May 18, 1958. He visited the district office in July 1958 and the Social Security representative assisted him in filing a "Request for Reconsideration." He also submitted a letter from another doctor as additional medical evidence at this time.

The State vocational rehabilitation agency arranged for a cardiologist to examine him at a hospital on September 15, 1958. This examination, at the expense of the Government, included an electric cardiograph and a fluoroscopy. Mr. ——— commented that the doctor was very friendly and courteous.

The applicant received a letter dated October 25, 1958, notifying him that his application for disability insurance benefits had been reconsidered and that the original denial determination was found proper and in accordance with the law.

With the assistance of the district office representative, he filed a request for a hearing "in person" before a referee on February 2, 1959. Mr. ——— did not feel that he needed anyone else to represent him at the hearing. The hearing was held about 5 months after his request for the hearing.

Mr. ——— was satisfied that he received a fair hearing. The referee listened to everything the applicant had to say and acted as a gentleman throughout the hearing. The applicant believes the decision was correct because he is still working.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I interviewed this 64-year-old applicant on December 30, 1959. Mr. ——— lives with his wife in a nicely furnished brick home. He has

been unemployed since November 1956 and lives off of his savings and a small company pension. He seemed to answer my questions with sincerity and frankness but digressed many times during the interview to relate personal experiences which had no connection to the subject of the interview.

Mr. ——— learned of the social security disability program from his company supervisor who also told him of the location of the nearest district office. The applicant stated that every time he visited the district office he always had to wait at least an hour before a representative talked to him and on one occasion waited 1½ hours before being taken care of. He states that Social Security representatives are slow and take their time. Mr. ——— stated that on one visit the representative that took care of him was drunk and it tried his patience to deal with the individual. He states that he does not want to make trouble for anyone and would refuse to acknowledge this fact or identify the person if he was requested to do so. The applicant stated the district office manager informed him that all they did there was to fill out forms and they could give him no information about the disability program. He stated that he was encouraged to file an application for benefits under the disability program. The only assistance given to the applicant by Social Security representatives consisted of filling out his application and giving him medical report forms to be completed by his doctors. After his first visit to the district office he felt that he needed some assistance in preparing his claim but he did not receive any. Mr. ——— took the medical report forms to his family doctor and to a surgeon. Both doctors completed the forms from their records without giving a current medical examination and the applicant was not charged for the preparation of the reports.

Prior to making a disability determination the State vocational rehabilitation agency sent the applicant to Dr. ——— for a physical examination.

When the applicant received his notice of denial, he was satisfied with the reasons given for his claim being denied and did not intend to pursue the matter further. Some time later Mr. ——— received a letter notifying him that a hearing was to be held on his claim. The hearing had been requested by a friend without the applicant's knowledge or consent. He appeared at the hearing "in person" and stated that he was treated courteously by the referee and agreed with his decision.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant denied after hearing

Mr. ——— was interviewed on December 17, 1959, at his residence. Mr. ——— said he is 58 years old, married, and not currently working. Although at the start of the interview Mr. ——— was rather reserved, he was cooperative during the interview. He is a very businesslike person who appeared quite intelligent and he answered the various questions frankly. He referred to his affliction many times during the interview. He also spoke of his son many times ex-

plaining that his son is a lawyer and that he helped in the processing of his claim and appeal.

Mr. ——— said he was the manager of a group insurance department prior to his disability retirement and that is where he acquired his knowledge about the social security disability program. He said it was his business to know about it. He knew the location of the Social Security district office and he and his son went there to file his claim. He said he did not have to wait at all to file his claim and was not subjected to any discourtesy. He said they did not explain his rights under the program or the degree to which he had to be disabled in order to qualify and that they didn't have to because he was already familiar with this. The district office representative did not express a feeling either way as to whether he should file his claim or not. He said he went to the district office with the intent to file.

He said that he and his son filled out the application for disability benefits. To get his medical proofs he delivered the forms, provided by the district office, to his doctor, whom he had been going to for 25 years. Other than his "regular" examination, his doctor did not give him a special examination and he was not charged for the preparation of the report. He did not deliver or mail any other forms to doctors and he is certain the district office did not obtain any reports from other doctors or hospitals.

He did not feel that he needed further assistance after his visit to the district office and no organization or person except his son helped him. He did not have any unfavorable comments to make about the way the district office treated him but did say he was impressed with the efficiency and the neatness of the office and that he had not expected a Federal office to be that well staffed. He further said that the representative that helped him was very conscientious and very well qualified.

Mr. ——— was noncommittal as to whether the denial letter satisfied him or not. He said he had been retired from his own company on a total and permanent disability and that they were strict so he thought he had a good chance on appeal. He said, I never like to give up, so naturally I wanted to take advantage of the appeal. Prior to the appeal, he said, the only reasons he received that his claim was denied were in writing and that the denial letter was sufficient to inform him of his rights to an appeal. He could not remember the district office informing him that he could submit additional evidence. He visited the Social Security contact station to request a hearing. After he requested the hearing, he said, he was examined by a State doctor at the request of the district office.

He could not recall if he was told by the Social Security people that he had his choice of the type of hearing; however, it was his understanding that he did not have a choice and that the hearing had to be before a referee in person. Mr. ——— said he could not remember if the Social Security people told him he could have a lawyer or someone else represent him at the hearing. His son, he said, told him he could and, therefore, he had his son present at the hearing for which his son made no charge.

When asked if he felt that he got a fair hearing he said, "Yes, that's a surprising statement, but yes." He said the referee definitely treated

him courteously and that he felt the referee's decision was correct. He felt the referee was a sincere person doing his job. He was told by the referee that he could appeal the decision to the Appeals Council but he said in light of the referee's decision and after discussing it with his son he did not believe it would be worth while. He could not recall if he was told that he could take his case to the U.S. courts but said his son told him he could and he understands from his son that there would be a \$40 filing fee to do so.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

On December 4, 1959, I called on this applicant at his home. His home was small, dirty, and in a poor and rundown section of the city. Mr. ——— could not stand erect and appeared to be extremely uncomfortable even when seated. He coughed several times during the interview and on several occasions strained to get his breath. Mr. ——— had little formal education and his mind seemed to wander at times during the interview. His only apparent means of support is that which he receives from public welfare and an occasional assist from a neighbor. Despite his rather pitiful existence, he appears rather good natured and apparently has reconciled himself to the fact that this is his fate.

Mr. ——— was advised of the disability program through the department of public welfare and they arranged an appointment at the Social Security district office. He stated he waited about one-half hour before being seen by the district office people. Mr. ——— does not remember the district office explaining the disability program to him nor does he remember being told how disabled a person must be to qualify. Mr. ——— emphasized several times how courteously he was treated.

From Mr. ———'s statements, it appeared that the district office with the aid of the department of public welfare handled the case completely, requiring him to merely answer questions and submit to a medical examination. The applicant states he was not charged for this or any other medical examination and if the district office secured any other reports, the department of public welfare took care of them. He confessed he would have been at a complete loss without the department of public welfare's assistance.

When Mr. ——— received his denial letter from Social Security he was surprised that he had been turned down and immediately went to the department of public welfare to get their explanation of the letter. The department of the public welfare told him that he was turned down because his "sickness was not bad enough," but stated they would see if something couldn't be done. He had to submit to another medical examination but without cost to himself. Mr. ——— seemed very vague as to whether he was actually given a hearing or not. Evidently, his case was reviewed without him being there. He couldn't distinguish between the regular part of his case and the hearing part, since to him it seemed merely a series of trips to the district office, department of public welfare, and doctors' offices.

Mr. ——— was advised by the department of public welfare, after receiving his second denial, that he had done about all he could unless his condition got worse. Since he has put himself in their complete care he apparently is satisfied.

I thanked him for his cooperation.

INTERVIEW WITH DIRECTOR, DEPARTMENT OF PUBLIC WELFARE

Mr. ———, one of the applicants interviewed in our survey, stated he had been assisted in filing his application for disability benefits and in the preparation of his case by the department of public welfare. The applicant emphasized that the department of public welfare helped him process his case from beginning to end including the hearing. He added without them he would have been at a complete loss. Likewise other interviewees mentioned that they had been assisted by the department of public welfare although perhaps not as extensively as Mr. ———.

I met Mrs. ———, the director of the department of public welfare, in her office on December 30, 1959, to discuss the department's role in dealing with such disability applicants. Mrs. ——— personally does not come into contact with these individuals and was not familiar with this aspect, but promised to arrange an interview with the social worker who handled Mr. ———'s case or someone else who handles the same type of cases.

The director stated that one of the department's primary functions is to see that the individual coming to them secures benefits from all sources to which he is entitled—e.g., social security disability program, Veterans' Administration disability program, or Workmen's Compensation fund, etc. She emphasized that great pressure is exerted on her office to see that this function is fully carried out. The reasons she explained are twofold. First, the individual is no longer a financial burden of the public welfare department and secondly he is put back on a self-sustaining basis which normally improves his psychological outlook.

Mrs. ——— claimed that the public welfare department often subsidizes disability program payments when they are small and when a great deal of medical assistance is needed. She explained that her office contacts Social Security to determine each individual's status and the amount of aid given is dependent upon whether the individual is receiving payments and, if so, in what amount.

I thanked Mrs. ——— for her courtesy and told her I would be looking forward to talking to one of her social workers on the subject.

INTERVIEW WITH SUPERVISOR, DEPARTMENT OF PUBLIC WELFARE

I met Mrs. ——— in her office Friday, January 8, 1960, as arranged by Mrs. ———, director of the public welfare department. Mrs. ——— supervises a group of public welfare caseworkers and although she does not come into contact with the applicants personally she is well informed through her many years with the welfare department.

Mrs. ——— said that the social security disability program is not generally well known among persons coming to them for assistance. She added that the vast majority believe the only benefits due them under the social security program are old-age benefits payable at age 62 or 65 regardless whether a disability exists or not. Mrs. ——— stated many of their applicants are disabled, the disability being the reason they are placed in need of public assistance to begin with. Because of their impairment they are either unable to find or hold a job and those without other means must come to them.

One of the first things the department of public welfare does when a new applicant comes to their office is to check his status with Social Security. If the applicant has not filed and is entitled to either old-age or disability benefits the department will exert every effort to see that he follows through and files an application. They normally arrange an appointment with the local Social Security district office, orient the applicant as to some of the proofs and documents he will need, and advise him of what he may generally expect upon going to the district office.

The caseworker will attempt to keep current on the progress of each individual's case to which she is assigned, to see that the person keeps appointments, answers letters and follows instructions given him by the Social Security district office. Likewise, the welfare department endeavors to keep the applicant currently advised of his case's progress. This is especially true with disability applicants. If the applicant has been denied benefits they make certain that he is aware of his appeal rights and assist him if he decides to carry his case further. Mrs. ——— stated the degree of such assistance given depends on the individual himself. Some of their applicants require little or no assistance, others must be figuratively "led by the hand" through the entire processing of their case.

Mrs. ——— explained that a very harmonious and cooperative relationship exists between the two offices. She commented that in all the dealings she has had with Social Security—and added that she spoke for her coworkers as well—she has been treated most courteously and in a very businesslike manner.

I asked Mrs. ——— if she had any other general comments on the disability program. She said it is sometimes difficult for the Department of Public Welfare to understand the decision made by Social Security regarding a disability. They have had cases where their doctors have definitely determined the applicants to be disabled and unable to perform any type of work, yet in the same cases the applicants were turned down for disability benefits under the Social Security program because their disabilities were not considered severe enough to preclude all work according to Social Security standards. Mrs. ——— feels there should not be this wide variance between the two programs. She also wondered why the Social Security did not make use of the Department's medical reports on applicants who come under both programs. Often the individual when applying for assistance from their Department must submit to medical examinations, tests, X-rays, etc., and later when applying under the social security disability program must undergo like examinations, tests, and X-rays. This duplication of effort is not only costly and time-consuming, but places an additional hardship and inconvenience on the disabled applicants.

The final comment Mrs. ——— made was in reference to the extensive time involved in processing disability cases by Social Security and the wide time variance between cases. This places the Department of Public Welfare at a decided disadvantage because they are unable to set any standard as to how long they will have to carry an individual before a decision is reached by Social Security. Mrs. ——— added that she could readily understand some of the problems Social Security had and remarked that they have noticed some improvement recently in the processing time of cases which come to their attention.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I made an appointment by telephone to interview this applicant on January 5, 1960. Mrs. ——— lives with her husband and son in a 6-room house. Both her husband and son were present during the interview but neither attempted to influence the applicant in regard to the statements made by her during the interview. She has been unemployed for 2 years and her husband is currently receiving Social Security old-age insurance benefits. She seemed to answer my questions with sincerity.

Mrs. ——— learned of the social security disability program from an acquaintance who suggested that she have her wage record frozen in order to protect her old-age insurance benefits. She obtained the address of the nearest Social Security district office from an employee of the State unemployment office. On her first visit to the Social Security district office the disability program was explained sufficiently enough to enable her to decide to file an application for disability benefits. She was always treated courteously by district office representatives and never waited more than 15 minutes before a representative talked to her. Mrs. ——— stated that the assistance given by district office representatives consisted of filling out her application and requesting medical reports from a hospital and one doctor. Because of her lack of knowledge about the disability program she placed complete reliance on district office representatives in handling her case. The applicant took a medical report form to her current family doctor who gave her a medical examination prior to completing the form. She was not charged for the preparation of the report but was charged for the physical examination.

Prior to making a disability determination the State vocational rehabilitation agency sent the applicant to another doctor for a physical examination. When Mrs. ——— received the initial notice of denial she was not satisfied that a proper determination had been made in her case and went to the district office to request a hearing. The district office representative did not attempt to explain the reason why her claim was denied. They informed her that in connection with her appeal she could submit additional medical evidence, however, in telling this to the applicant the representative stated that not too much attention is paid to medical reports furnished by the applicant. The representative was noncommittal about the outcome of the applicant's appeal. The applicant, who appeared at the hearing in

person, knew that she could have had a lawyer or someone else represent her but she refrained from obtaining such assistance as she could not afford it.

Mrs. ——— believes that the hearing was "the rottenest thing on the face of the earth." She stated that during the hearing the referee asked questions which she believed were not pertinent to her case and claimed that the referee "talked to you like you're dirt." To illustrate these assertions she stated that the referee inquired into such things as family living expenses and also brought out that he only allowed her to answer "Yes" or "No" to questions she felt needed fuller explanation. Mrs. ——— does not concur with the referee's decision and stated that she was not informed of her right to a review by the Appeals Council in Washington or the fact that if she were still dissatisfied she could take her case to the U.S. courts.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

Mrs. ——— was interviewed on December 22, 1959, at her residence. Mrs. ——— said she is 58 years old and has not worked since November 6, 1954. She lives alone, in squalor, in a very poor section of the city. Her home is a run-down, one-room, barn-like place. She has four dogs and feeds scraps to all the cats in the neighborhood. She is quite crippled as was observed some distance from her home when she was moving about outside. She seems emotionally upset. She gets \$92 a month State aid.

Mrs. ——— said her sister advised her about the social security disability program. She said that when she visited the Social Security district office she waited about 5 or 10 minutes before someone talked to her and she was treated courteously. The disability program and her rights under it were fully explained to her. She does not remember now if the district office representative described how disabled she would have to be in order to qualify for Social Security disability benefits but she does not believe so. She said the district office representative tried to discourage her from filing an application for disability benefits.

Mrs. ——— said the district office representative filled in application forms from information she furnished and that she signed the forms. She said a medical report form was sent by the district office to her doctor for preparation. She was not charged for the preparation of this form. The doctor did not actually examine her at the time of the preparation of the form. She did not take or mail medical report forms to other doctors and she has no way of knowing if the district office obtained reports on her case from doctors or hospitals. Mrs. ——— said she felt she had enough assistance at the district office in the preparation of her claim for social security benefits and did not have help from any other person or organization. She had no other comments on her treatment by the district office except to say that she was treated well.

Mrs. ——— said she was not satisfied with the letter received from Social Security Administration denying her claim for disability benefits; therefore, she asked the district office to reopen her case. She

telephoned the district office to ask the reason for the denial of her claim and was told there was insufficient medical evidence established. She was also told she could appeal her case and that she could submit additional medical evidence.

The district office, she said, obtained two other medical reports from doctors. One report was from a doctor who handled her claim on an insurance policy. Then the district office sent her to another doctor for a medical examination. She was not charged for this examination.

The district office, she said, told her it would be OK to have her case heard before a referee. She could not recall if she was told by the district office that she could have a lawyer or someone else to represent her at the hearing of her case but did say that she did not have a lawyer or anyone represent her at the hearing. She also said that she did not obtain help from anyone else in the preparation of her appeal.

Mrs. ——— said she received a letter from the Social Security Administration requesting her to appear before a referee. She said she appeared at the hearing and is not satisfied that she got a fair hearing of her case. She was treated courteously by the referee, she said, but does not believe his decision was correct. She said she did not know that she could ask the Appeals Council in Washington to review her case. She appeared confused about this because attached to the referee's decision dated July 29, 1959, is a letter informing her of her rights to have the Appeals Council in Washington review her case. She does not recall whether or not she was informed by the referee that she had the right to this review and that if she was not satisfied she could take her case to the U.S. courts.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

In contracted this 63-year-old applicant by telephone and made an appointment to see him December 4, 1959. He lives with his wife in a small and very neat cottage. Mr. ——— appeared to be almost totally blind and his general physical appearance indicated that he is not in good health. He is also hard of hearing. Mr. ——— lives on a \$90 a month retirement and disability pension. Mr. ——— had his son present at the interview to help him.

Mr. ——— stated that his former employer kept him on the payroll for several years even though he could not perform his job as timekeeper. The company suggested that he file a claim for social security disability benefits and made an appointment for him at the Social Security office. He waited 45 to 60 minutes before the Social Security representative saw him. The Social Security representative did not explain the disability program nor did he tell him how disabled he had to be. The Social Security representatives were courteous but did not help him understand the disability program. Mr. ——— requested, by mail, medical evidence from the company and his family physician. He took the medical report to his family physician who gave him a current medical examination. The doctor charged for the current medical examination but did not charge him for filling out the medical report. Mr. ——— stated that the Social Security representative did not secure evidence for him. The only

help he got in filing his claim was from the company and his son. Mr. ——— emphasized that the Social Security representative never explained the disability program but only read questions to him from forms.

The State vocational rehabilitation agency, prior to making the disability determination, sent Mr. ——— to another doctor. Mr. ——— stated that the doctor was not friendly and kept him waiting 1½ hours. Although he didn't mind this, Mr. ——— stated that the doctor gave him practically no examination. The doctor briefly looked at his eyes with a flashlight and held a card in front of him. Mr. ——— was not satisfied that this was a fair examination.

Mr. ——— showed me his denial letter and pointed out that it had very little explanation of his denial. Mr. ——— did not contact the local Social Security office again but had his son write a registered letter asking for a hearing. Mr. ——— did not feel that the hearing required a lawyer, but had his son accompany him. The hearing was held about 5 months after his appeal request and about 1 year after he first filed an application. All information concerning the hearing was based on the hearing notice and no attempt was made to contact the Social Security district office.

Mr. ——— praised the hearings examiner and commented that he took his time, was courteous, explained the issues, and reviewed the evidence in a very thorough manner. Mr. ——— does not believe that the referee's decision was correct. He stated that it was doubtful that eye surgery would help him and being age 63, he couldn't get a job anyway. Mr. ——— stated that he can't understand why he was refused benefits while a neighbor, who is only 58, gets disability benefits and is able to drive a car and get around. Mr. ——— can't leave the house without assistance. Mr. ——— did not know that he could have asked the Appeals Council in Washington to review his case. Mr. ——— also did not know that he could take his case to the U.S. courts. Mr. ——— felt it probably wouldn't change the results even if he had known of his appeal rights. He thought the cost of taking a case to the U.S. courts would be prohibitive. Mr. ——— is not presently working.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

Mr. ——— was interviewed on December 17, 1959, at his residence. Mr. ——— said he is 62 years old, a bachelor, and is not presently working. He is retired, he said, from his company under a company disability program. Before any specific questions were asked he said that when his claim was settled it was a relief to him and he would not want to go through it again because of the mental strain involved.

Mr. ——— said he found out about the social security disability program from his employer. He was informed by a letter from his company to go to the Social Security district office to file his claim for disability benefits. At the district office, he said, he had to wait about a half an hour but that didn't bother him. He was treated in a businesslike and courteous manner and, he said, the representa-

tives seemed to enjoy their work. His rights under the disability program were explained to him and, in addition, he was given a bureau publication, "If You Are Disabled." In order for him to qualify for benefits, he said, the representative told him he would have to be disabled to a degree that would prevent him from doing work of any kind. The attitude of the district office people as to whether he should file his claim or not, he said, was neutral.

Mr. ——— said he could not remember if he received any help in filling out the application for disability benefits. He said the representative asked him questions and was very thorough in explaining things. He said he took some forms home, filled them out, and mailed them back to the district office.

Shortly after the onset of his illness he was referred to a private doctor by his company doctor. He took the medical report form to this doctor who gave him an examination prior to filling it out. There was no specific charge for the preparation of the forms but he was charged for the examination. He did not know whether the district office received any reports from other doctors or institutions. He did not take or mail any report forms to other doctors.

Mr. ——— said he did not feel he needed additional assistance after his visit to the district office, and that the personnel manager at his company kept him current on his case. That was the only person or organization that helped him during the processing of his claim. He felt the district office personnel were doing a good job and that they could not have treated him more courteously.

Mr. ——— said the denial letter he received did not satisfy him as to why his claim was denied. He said it was an impersonal mimeographed letter that "hit him like a ton of bricks"; it did not tell him why his claim was denied and he felt that a regular letter explaining the conclusions reached by the people who processed the claim would have been better. He said he wanted to find out who was right. He was considered disabled by his company but not by Social Security. He had said previously that his private doctor told him he could do a light form of work but his company did not have anything of that type.

After receiving the letter of denial he went to talk to a field representative at the Social Security contact station. He said the representative did not explain why the claim was denied but did tell him that he could appeal the claim and that he could submit additional medical evidence. The representative did not advise him one way or the other as to whether a hearing should be requested or not. He understood everything the representative told him.

Mr. ——— said that after his request for a hearing he had an examination by a State doctor which had been arranged by the district office. He was not charged for this examination. The only other help he received was from the personnel manager of his company. He was told by the field representative that he could have a lawyer or someone else represent him at the hearing and he chose the personnel manager of the company to represent him. He said he had the personnel manager represent him because he wanted the benefit of his knowledge and because he felt "shaky." There was no charge for the representation.

Mr. ——— thought the field representative told him he could have the kind of hearing he chose. He said he requested a hearing in person and about a month later received a letter of appointment for the hearing.

Mr. ——— said he believed he got a fair hearing and he thought the referee's decision was correct insofar as the Social Security interpretation of disability is concerned. He said he was treated courteously by the referee and that he was not "underhanded" at all; however, he felt that the referee's decision was made up by someone else before the hearing. He was glad they found he was not so disabled that he could not do any work but said that he is still confused about the conflict between the company's determination of a disability and Social Security's. He could not recall if he was told he had the right to appeal his case further through the Appeals Council or the U.S. courts. He does not intend to take any further action on his claim.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I made an appointment with this 65-year-old applicant for December 29, 1959. The applicant has been unemployed for about 4 years, except for odd jobs for the owner of a restaurant at various times. Mr. ——— seemed to answer my questions with sincerity.

Mr. ——— learned of the social security disability program from a friend of his and was informed of the location of the district office by many different people. On visits to the Social Security district office he never had to wait more than 15 minutes before a Social Security representative was able to see him. Mr. ——— felt that while he was treated all right by Social Security personnel he was given a "run-around" with respect to establishing his date of birth. Social Security representatives never explained the disability program, the rights under it, and the disability requirements to the applicant. Mr. ——— claims that he was encouraged to file an application by Social Security personnel who stated that they wanted to help him. The applicant stated that he prepared his own application but that the district office sent for a hospital record from the Veterans' Administration hospital where he was hospitalized in November 1957. He did not obtain a medical report from a doctor because he could not afford it.

Prior to making a disability determination the State vocational rehabilitation agency sent the applicant to Dr. ———. Mr. ——— had no comment about the examination that was given by Dr. ———.

Upon receipt of the denial letter Mr. ——— stated that he requested a hearing because he felt he was disabled and therefore entitled to benefits under the disability program. Prior to the hearing the district office obtained additional medical evidence from the Veterans' Administration hospital. Mr. ——— was not informed by Social Security personnel that he could have a lawyer or someone else represent him at the hearing. He was told that he could have a hearing in person before a referee or he could have the referee decide his case from the papers in the record.

Mr. ——— stated that he was treated courteously and was satisfied as to the fairness of the hearing and he felt that there was nothing that he could do about the decision of the hearings examiner. He was not aware that he could have his case reviewed by the Appeals Council in Washington nor did he know that he could take his case to the U.S. courts.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

The applicant, Mr. ———, was cooperative and answered all questions. He was married and his wife was present at the interview on December 7, 1959.

The applicant stated that the district office treated him like a public assistance case. The district office told him that a State vocational rehabilitation employee would call on him to assist him. No one has called.

The applicant said that the disability program is not uniform throughout the United States. He has a friend living in another State who was awarded a benefit and the man can get around better than he can. The applicant is convinced that his particular district office is unusually hard on disability cases. He says that friends also tell him this.

The applicant believes that some medical assistance should be available for disability applicants. He thinks that people who cannot pay for the medical evidence are not applying for benefits. The applicant last worked in September 1959 for about 3 weeks.

The doctor treating Mr. ——— suggested that he apply for disability benefits. He had to wait about 30 minutes in the district office to file his application. He was treated very courteously. The clerk in the district office did not explain how disabled the applicant had to be before he was eligible for benefits. The clerk stated that it would be up to the doctor. The applicant does not understand why his age (63) does not have some relation to his disability. The Social Security representative told him that his age had no bearing on his disability determination. He thinks, however, that his age plus his disability makes it impossible for him to obtain employment.

The applicant was given some forms to bring home and fill out and some to take to the doctors. The district office told him that he should have statements from two doctors. His impression of the district office was that they just hand out forms. The doctors gave him a current medical examination and charged him for the examination. The applicant also stated that the doctors charged for filling out the medical report. He said the doctor charged him every time he went to his office. The applicant asked the district office if they could furnish a doctor for the medical report but he was told by the district office that the State did not have doctors for this purpose. The applicant did not feel that it was necessary to have assistance to fill out the forms given him by the district office.

The district office was never able to explain satisfactorily to the applicant why he is not eligible for benefits. Every time he tries to work his legs give way. The clerk in the district office told him about

his rights to a hearing before a referee. He was told to submit additional medical evidence by his own doctor. He was not examined by a consulting doctor or a State vocational rehabilitation doctor. The applicant was told that a witness was necessary at the hearing to testify about his disability. His wife served as the witness. He was also advised that he could obtain legal counsel but was told it was not necessary.

The district office gave him the forms to fill out for an appeal but offered no help on how to present the evidence.

The applicant is very bitter about his experience before the referee. He feels he was treated courteously but he did not like the attitude of the referee. The referee treated him like he was a public assistance case.

Mr. ——— and his wife had to wait 1½ hours past their appointment with the referee before he was interviewed. The referee told him that if he could wash dishes, mow the law, or sell newspapers that he was not entitled to disability benefits. Mr. ——— said he felt like getting up and walking out in the middle of the hearing.

After receiving the referee's decision the applicant decided not to do any more about his case. He just feels like there is nothing more he can do. Mr. ——— stated that he didn't think anyone should sue the U.S. Government.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

Mrs. ——— was interviewed on December 11, 1959, at her residence. Mrs. ——— is a woman of Italian descent, who could speak fairly good English but it was explained by her daughter that she could not read or understand English very well. Her daughter was present during the interview and acted as interpreter. Each question was directed to the applicant's daughter because her mother was watching her for approval. They would converse in the native tongue and the daughter would answer the questions. The daughter explained that she had read all of the letters received from the Social Security Administration to her mother and that although she had not accompanied her mother to the Social Security district office or the hearing she had discussed the matter with her on many occasions.

The applicant's daughter said that to this day she doubts whether or not her mother understood what was going on and she doubts that the people to whom her mother talked understood her very well. She said that she was certain her mother did not understand any details. All of this, she said, was caused by a language barrier. She said that to her knowledge no one ever asked her mother if she understood the proceedings. She was not represented by anyone at any time.

Several of the questions the applicant tried to answer herself but she seemed to get very excited in trying to express herself. Her answer would just ramble around the subject. She was asked if she understood what the district office people did for her and was asked on occasions if she understood the questions. She said "Yes," but her daughter explained that her mother always says yes whether she

understands or not. She said that her mother would be better off if she told people once in a while that she did not understand.

The applicant said she found out about the disability program from her family doctor who told her where the district office was located. She went to the Social Security district office alone and she said that someone did come to her home but she did not know where he was from. He was concerned with her physical condition.

Mrs. ——— said that when she went to the district office she had to wait about an hour but was treated courteously and they did not "push or rush" her. The district office representative explained to her that she had to be disabled to a degree that would prevent her from working but she could not recall whether her rights under the program were explained or not. Mrs. ——— said she made up her own mind to file for benefits. The district office representative neither encouraged her nor discouraged her.

Mrs. ——— said the district office people did everything for her including filling out the application and mailing the medical report form to her doctor. She had been going to her doctor before she filed for her benefits and he did not give her a special examination for social security purposes. She was examined by three doctors other than her own (they were chosen by the Bureau after the claim was appealed). She did not take or mail any forms to any of the doctors. There was no charge made by her own doctor for filling out the form nor did the other three doctors charge her anything.

No other person or organization helped her with her claim and she did not think that she needed further assistance. The applicant's daughter said that applicants like her mother should have an interpreter help them.

Mrs. ——— said the denial letter did satisfy her that she was not totally disabled and she and her daughter both agreed that the disability was not of a permanent nature and that it was of a recurring type that she got each winter. The district office people, she said, explained to her that the disability was not total and permanent. Even though she understood that she was not totally disabled she explained that she could not get and keep a job if she could not work full time. She said it was hard enough for a foreign person to get a job.

Mrs. ——— said the district office did tell her that she could appeal her claim and submit additional evidence but there were no comments made either way as to whether or not she should appeal. After she requested a hearing she was examined by the three doctors provided by the Social Security Administration but she did not get help from anyone else. She was not told by the district office representative that she could have a lawyer represent her at the hearings nor did anyone represent her at it. She could not remember the representative telling her that she had her choice of the type of hearing she could have but thinks he just told her it would be in person.

She would not say whether she got a fair hearing or not but said she would have to assume she did. She did not have any objections to how the referee treated her and she agreed with the referee that she was not permanently disabled. But she did not understand how they expected her to get a job. She could not remember whether or not she was told that the Appeals Council or the U.S. courts were available to review her case. The applicant's daughter said her

mother would not fight a decision like the referee's because she could not put her point over alone. Mrs. ——— is not currently working.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I made an appointment with this 55-year-old applicant for January 4, 1960. The applicant lives with her husband in a three-room apartment. Mrs. ——— seemed to answer the questions with frankness and sincerity. She has been unemployed since November 1954.

Mrs. ——— learned of the social security disability program from a friend during a visit to New York. On her first visit to the district office the Social Security representative explained the disability program and she decided to file an application for disability benefits. The applicant never had to wait more than 20 minutes before someone talked to her on her visits to the district office. She stated that on her visits to the district office she was always treated courteously by representatives. District office representatives never described to her how disabled a person had to be to qualify for benefits under the program. Mrs. ——— stated that she did not receive any help from Social Security representatives in preparing her case. She obtained medical reports from three doctors. One of the doctors hospitalized the applicant after an initial examination in the doctor's office; the other two doctors submitted medical reports on the basis of their records on the applicant. She was not charged for the preparation of the medical reports.

Prior to making a disability determination, the State vocational rehabilitation agency sent the applicant to another doctor for a physical examination. When Mrs. ——— received the notice of denial, she was not satisfied with the determination and visited the district office. The Social Security representative did not attempt to explain the reason why her claim was denied but informed her that she could appeal her case and that she could submit additional medical evidence. The representative did not give the applicant an opinion as to the outcome of an appeal. She obtained additional medical evidence from one doctor prior to the hearing but received no help from the district office in obtaining additional proof of her disability. She was not informed by district office representatives that she could have a lawyer or someone else represent her but thought that she had to appear at the hearing in person.

Mrs. ——— was not satisfied that she was given a fair hearing. She stated that the referee recorded the proceedings of the hearing but that at various times the recording was shut off prior to the applicant giving explanations to her answers. During the hearing the referee asked the applicant to go to a window and watch a parade. The applicant stated that she told the referee several times that she was not able to stand for any length of time. She then went to the window for a moment and then returned to her chair. After the hearing was over, the referee asked her to stay and watch the parade. These facts were brought out in the referee's decision as follows:

"However, it was noted that when she was suddenly invited to the window to view a passing parade, she moved with alacrity and ease."

After she received a copy of the referee's decision, she called him and confronted him with the manner in which the incident was reported and he would not comment on it. Mrs. ——— believes that she got a "raw deal." The applicant was not informed of her right to a review by the Appeals Council in Washington or the fact that if she were still dissatisfied she could take her case to the U.S. courts.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

On December 18, 1959, I interviewed the applicant at her home. Mrs. ——— and her husband live in a small frame dwelling. The house is in a very poor state of repair. Mrs. ——— appeared to be a sincere and intelligent person.

Mrs. ——— first heard of the social security disability program over the radio. She had broken her leg and the Social Security representative came out to her home to see her. She commented that the Social Security representative was very courteous and seemed to explain the disability program to her. The representative also left a booklet explaining the disability program. Mrs. ——— recalled that the Social Security representative did not encourage her since he thought she would be able to go back to work soon.

The Social Security representative mailed an application to Mrs. ——— who filled it out and mailed it back. She mailed one medical report to the surgeon who treated her. Mrs. ——— does not recall whether she sent a medical report to her family physician. The doctor did not charge for completing the medical report. She does not know whether Social Security got any additional evidence from other sources. Mrs. ——— mentioned that she did not receive any physical examination in connection with her claim. Mrs. ——— did not feel a need for nor did she secure any assistance in filing her claim.

After Mrs. ——— received her denial notice she went back to the Social Security district office. She doesn't remember the explanation given for her denial but she filed a hearing appeal. She stated that her initial claim was made in June 1958 and the hearing request in July 1959. She does not remember whether the Social Security representative told her that she could submit additional evidence. It seemed to her that the Social Security representative did not have much to say as to whether her denial should be appealed.

Mrs. ——— stated that she was not told she could have a lawyer or someone else represent her at the hearing. She did not appear personally at the hearing since it was physically difficult for her to make the trip and she didn't have the money to travel. She stated that the Social Security representative did not influence her decision not to appear in person before the referee.

Mrs. ——— is satisfied that she had a fair hearing and from what she knows of the disability program believes her denial was proper. She did say that she was unable to work for a year and 7 months and had hoped to get benefits for some of this time. During the year and 7 months she and her unemployed husband lived on \$81 a month from welfare and charity from friends. She stated that she was very lucky to again get employment in July 1959, at a clothing manu-

facturer where she runs a sewing machine. She makes \$36.18 if she works a full week. However she stated there are some weeks when the plant does not operate for a full week.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

Mr. ——— was interviewed on December 9, 1959, at his home. Mr. ——— said he is 60 years old, is not working and has not worked since April 22, 1957, the date of a bus-truck accident. He had 56 breaks in knee and lower right leg and is still in a cast. He has had two graftings on his leg and faces a third.

Mr. ——— said he read about the social security disability program in the local newspapers and he decided to go to the Social Security district office and file a disability claim to have his wages frozen as of the time of his accident, April 22, 1957. He did not wait long for attention in the district office and he was treated courteously. The disability program was fully explained to him together with his rights under the program. He was told that his case looked good. He had with him copies of medical reports from his doctor. He was given all necessary information needed so he could determine whether or not to file a disability claim.

Mr. ——— said that a claims representative at the district office filled in the necessary disability application forms from information he gave him. The district office forwarded medical report forms to a hospital requesting medical information. He said he was not charged for the preparation of the medical report. Mr. ——— said the hospital doctor did not examine him at the time of the request for the medical report but he had X-rays taken the day before he filed his application for disability benefits at the district office. Medical report forms were not mailed or taken to other doctors, he said, and he believed the only medical report obtained by the district office was from the hospital.

Mr. ——— said he had sufficient assistance in the district office in preparing his claim and needed no other assistance from any other person or organization. He has no complaints on the treatment given him at the district office as he was given all necessary assistance.

Mr. ——— said that he received a letter of denial from the Social Security Administration that his disability claim was denied and if he wanted to reopen his claim, he should furnish additional evidence and medical reports. He was not satisfied with the denial of his claim for disability so he decided to reopen his case. He went to the district office and filled in the necessary forms which together with additional evidence and medical reports were forwarded to the Baltimore office, Social Security Administration. He did not discuss the denial of his claim with the district office people. The Baltimore office advised him of his right to have a lawyer or other representative at a hearing of his case and set the hearing "in person" before a referee. He did not have anyone represent him at the hearing.

Mr. ——— is satisfied that he got a fair hearing of his case before the referee and said he was given courteous treatment. He said that he believes the referee's decision was correct according to the law,

provisions of which were quoted to him. However, he feels that medical and doctors' reports indicate inability to work. In other words, these reports, he said, show total disability as to time, i.e., the doctors cannot say when he will be able to return to work.

Mr. ——— said the referee advised him of his right to appeal to the Appeals Council in Washington and if he was still not satisfied, he could take his case to the U.S. courts. He has decided not to follow through on an appeal of his case as he feels the law may be changed to cover cases such as his.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I made an appointment by the telephone with Mr. ——— for December 17, 1959. He lives with his wife in a 5-room brick home in a nice section of town. Both he and his wife work. Mr. ———, 59 years old, is a barber and is presently working for subsistence income. He has an arrangement with his employer to work 4 days a week from noon to 6 when he is able. Mr. ——— stated that he works on a commission basis and his earnings average \$47 a week.

The applicant related that his heart started troubling him about 3 years ago and that he has had occasional dizzy spells and periods of breathlessness. Although Mr. ——— had some difficulty in recalling specific events I believe his comments were very frank and sincere.

Mr. ——— stated that he cannot recall the exact circumstances under which he found out about the disability program or how he ended up going to the district office. He stated he probably looked in the telephone book after reading about it in the newspapers or talking with friends. He waited about 10 or 15 minutes before the Social Security representative saw him at the district office. Mr. ——— visited the district office on three occasions and was treated courteously except for one instance when one of the district office employees told him "that you don't get something for nothing." He stated that the district office probably fully explained the disability program to him and his rights thereto indicating "it's just like when you file for State unemployment benefits or anything else." When asked if the district office encouraged him or discouraged him from filing, he stated they did not discourage him and that it would have done them no good to try since "I am a stubborn man."

The Social Security representative filled out Mr. ———'s application while asking him the questions. Mr. ——— signed the application and was given a medical report form for his doctor to fill out. Mr. ——— stated that he knew his family doctor for over 20 years and because of his doctor's familiarity with his case no current medical examination was made at the time his doctor filled out the medical report. He also stated that he was not sure if his doctor charged him for preparation of the medical report form since he is billed annually by the doctor. Mr. ——— stated he knew that a request was sent to a hospital for medical data on his case but that he personally took no further action to obtain additional medical proofs. The applicant sought no additional assistance in preparing his claim because he said that "an applicant must know somebody to obtain a benefit."

Mr. ——— after receipt of his first denial letter, of which he had no criticisms, requested a hearing. He stated that the district office representative in explaining why his case was denied merely repeated what was in the denial letter he received. Mr. ——— stated that he was not informed that he could submit additional medical evidence but that the State vocational rehabilitation agency arranged a medical examination for him with Dr. ———. Dr. ——— was very courteous and gave him a very thorough examination. The applicant stated that somebody told him Dr. ——— was a heart specialist. Mr. ——— stated that his family doctor had said that "he was lucky he didn't drop dead when Dr. ——— had him hop around the room."

The applicant believes that he was informed that he had to appear in person for a hearing and that if he could not attend on that specific date, the hearing would be postponed to a later date. He stated he was not informed that he could have a lawyer or someone else represent him at the hearing but that afterward he thought it would have been a good idea to have a lawyer with him.

Mr. ——— stated that the referee was very courteous and amiable and that all the comments at the hearing were recorded on a tape recorder. He was not informed of his right to ask the Appeals Council in Washington to review his case or of the right to take his case to the U.S. courts. Mr. ——— stated he was satisfied with the hearing he received and felt any further action of appeal by him would be futile. He stated his doctor told him that since President Eisenhower has been in office an individual with a heart condition does not have a chance for disability benefits.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I interviewed this 58-year-old applicant at his residence on December 10, 1959. He lives with his mother in a two-room apartment on the third floor rear of an old row house in one of the poorer sections of the city. Except for his hands, Mr. ——— appeared to be in good physical health. There are scarred skin tissues on the back of both hands which he claimed was a result of severe frostbite. He stated that he cannot open his hands fully and has trouble closing them. In damp weather both hands are numb and painful.

Mr. ——— stated that he had been a pinsetter and general porter in a bowling alley and got the frostbite while waiting for a bus after work. He also stated that the State vocational rehabilitation agency had never contacted him. He would like to have a job as he has not worked for the last 2 years and his mother has to work in order to support him.

He learned of the disability program through the newspaper. His claim was filed (15-minute wait) in the Social Security office. The Social Security representative did not explain the disability program fully nor did he tell him how disabled he had to be to file. The Social Security representative was very courteous and assisted him

in filing his claim by asking him each question and writing Mr. ——'s reply on the applications.

He took the medical report to his doctor who gave him a current medical examination without any charge. He did not seek additional assistance in preparing his claim.

The denial letter had very little explanation of the denial and therefore the applicant went back to the Social Security district office. At this interview Mr. —— felt that this Social Security representative was not as courteous as the interviewer had been in his initial visit to the district office. At this time he was asked if he wanted to make an appeal and was told, if possible, to submit additional medical evidence. The Social Security representative assisted him in filing an appeal to have a hearing "in person" before a referee.

After receipt of this denial notice, his doctor had him admitted to a hospital as an outpatient at no charge. He visited this hospital three times a week for 3½ months and received therapeutic treatments in which he exercised his hands. These hospital records were obtained by the district office and submitted to the referee as additional medical evidence.

Mr. —— and his mother attended the hearing and he is satisfied that he received a fair hearing of his case. He commented that he was treated very courteously by the referee even though he does not agree with the referee's decision.

Mr. —— stated that his mother's employer wrote a letter for him requesting the Appeals Council in Washington to review his case.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

Mr. —— was interviewed on December 16, 1959, at his residence. Mr. —— said he is 63 years old, married and not presently working. He said he retired as section manager of his insurance company on January 1, 1956. He quit other temporary and part-time work in April 1959. Mr. —— seemed intelligent and appeared to be in good health.

Mr. —— said that in his business he knew about the disability and eligibility requirements of applicants under social security. He said that when he visited the Social Security district office he waited about 10 or 15 minutes at the most before someone talked to him and he was treated very courteously. He could not say that the disability program and his rights under it were fully explained to him. He did believe it was necessary. He believes he was not told, nor was it even mentioned by the district office representative, how disabled he had to be to qualify for Social Security disability benefits. The district office representative, he said, gave him information which enabled him to make up his mind to file a claim.

The district office representative filled in application forms from information he furnished. He signed the forms. The district office, he said, mailed medical report forms to his doctor for preparation. The doctor did not charge him for the preparation of the form. His doctor did not examine him at this time because he had been a

patient for some time and the doctor knew his case history. Mr. ——— said he did not take or mail a medical report form to other doctors. He felt he had sufficient assistance in preparing his claim at the district office, therefore he did not have any help from any other person or organization. He believed the doctor's report furnished sufficient information to file a claim. He had no other comments on his treatment by the district office except to say that he was treated very well and satisfactorily.

Mr. ——— said he was not satisfied with the reasons given in the letter of denial of his claim received from the Social Security Administration and he is a little provoked that more weight was not given to the medical report which said he could not work in gainful activity.

He wrote to the district office and asked to have the case reopened. He received a letter in reply requesting he visit the district office. Mr. ——— said he could not remember if the district office representative told him the reason his claim was denied although he did recall that the letter of denial was discussed briefly. He said he was told that he could appeal his case and he was informed that he could submit additional medical evidence. He understands that his doctor forwarded an additional medical report to the district office. The district office representative told him he should appeal the case, he said, although he told the representative he was not going to fool with the claim further as nothing good would come of it. Mr. ——— said that after he requested a hearing the only assistance given him was the requested additional medical report from his doctor. He said he does not believe he was told he could have a lawyer or someone represent him at the hearing and he did not have anyone represent him as he believed he was capable of handling his own case.

The district office representative told him he would be called before a hearing officer. The hearing was held in the district office before the referee on July 13, 1959.

Mr. ——— said he is satisfied that he got a fair hearing of his case and that the referee was very generous in his treatment of the case. Mr. ——— said he was treated courteously by the referee but he does not believe his decision was correct because his doctor says he cannot be engaged in employment and the referee said he can be gainfully employed.

The hearing officer advised him he could ask for a review of his case by the Appeals Council in Washington. He will not do anything about it, he said, as he believes it useless to pursue his case further.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I kept an appointment with this 55-year-old unemployed applicant on January 4, 1960. Miss ———, a divorcee, lives with her unmarried son in an apartment. The applicant's income consists of sporadic alimony checks which she receives from her former husband and assistance from her son. The applicant has arthritis and while answering the door several times during the interview moved very slowly in apparent discomfort. I believe the applicant's comments were credible and sincere.

Miss ——— learned of the Social Security disability program through the newspapers. She telephoned the district office for information regarding the disability program and was told she would have to come in the office to file. The applicant stated she visited the district office several times and was treated very courteously on all occasions and waited only 10 or 15 minutes before someone talked to her except on one visit when she waited 45 minutes. Miss ——— stated that the disability program, her rights under it, and the extent of disability necessary for qualification of benefits were never explained to her; the applicant stated she asked about the computation of benefits and was told by the district office representative that their function is to just take information. The applicant stated that she believes the district office people were cautioned not to give out too much information. They did not try to influence her decision to file for benefits.

Miss ——— stated that the district office representative filled out her application while questioning her and then gave it to her to sign. She was also given medical report forms and instructed to have her doctors complete and submit them on her behalf. Miss ——— stated she had three doctors submit medical reports on her disability claim and that one doctor made a current examination at the time of submitting the report and that the other two prepared the reports from medical history they had on the applicant. Miss ——— stated that she paid one doctor for preparing the report and that her attending physician charged her the regular office fee for preparing the report and making the examination. The applicant stated she was hospitalized for tests and observation but does not know if the district office obtained any medical report from the hospital.

The applicant did not feel she needed additional assistance in preparing her claim but questioned the competency of the district office representative. She stated that the district office representative, after filling out her application, asked if she knew of any more questions she should be asked.

Miss ——— was not satisfied with the denial letters she received from Social Security because she feels the letter did not explain the extent of disability necessary for qualification in her case. Based on her dissatisfaction with the denial letter she went to the district office and was told that her disability was not severe enough to entitle her to benefits. The applicant stated that the district office representative did not try to influence her decision to request a hearing; however, she feels if the district office representative had known a little more about the disability program, the Government would have saved the cost of a hearing in her case. The applicant, who assumed that she had to appear at the hearing in person, stated that the district office representative told her that she would have to appear before three lawyers at the hearing without advising her that she could have a lawyer or someone else represent her. The applicant stated she was informed that she could submit additional medical evidence of her disability but did not do so and received no help from the district office in this regard.

The applicant feels that she received a fair hearing and stated that the referee was very courteous and decided her case correctly based on the law. However, she stated that one of the medical reports submitted on her behalf by a Dr. ——— was not in the file reviewed by

the referee and that she requested that this omission be acknowledged in the record of the hearing. Miss —— showed me the transcript of her hearing and an attached cover letter informing her of further rights of appeal.

The applicant continually questioned me as to why the Social Security Administration did not inform applicants that disability benefits are a form of relief to be paid only if the disabled person is destitute. I asked the applicant what she based this belief on and she stated that when she filed her application she was questioned by the district office employee as to the amount of her family income and as to whether or not she was due an inheritance or owed any inheritance tax. The applicant interpreted these questions as an investigation of her financial resources as a limiting factor in determining whether or not she could qualify for disability benefits. She also criticized newspaper articles written on the disability program which she believes "overplay the program." She believes these articles increase the administrative costs of the Government in processing claims of ineligible but misinformed claimants.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I met with Mrs. —— in her home on December 22 1959. Mrs. ——, 56 years of age, lives with her son in a neat four-room apartment. She stated she is currently working 39 hours a week as a waitress for \$1 an hour. Mrs. ——, who worked as a waitress prior to the onset of her disability early in 1957, explained her present job as a temporary fill-in position obtained through a relative which will last only 1 month and enable her to pay her rent and other current expenses. I believe Mrs. ——'s comments regarding her treatment under the disability program were credible; however, she frequently digressed from the intent of the interview to relate her current domestic problems resulting from her disability.

Mrs. —— learned of the disability program and the location of the district office through a customer while working as a waitress. She stated that the Social Security representatives explained the disability program and her rights under it to her and were courteous to her on her four or five visits to the district office. She stated she had to take a number and wait a short time before someone talked to her on her several visits to the district office. Mrs. —— stated that the district office representative merely processed the application at her request without giving an opinion as to whether or not she could qualify.

Mrs. —— feels she received no help from the district office representative in preparing her case. However, she stated that he filled out her application based on her answers and then gave it to her to sign. He also gave her medical report forms for her doctor to fill out. Mrs. —— stated she took the medical report to her attending physician who charged her the regular office fee of \$5 for filling out the report and making the examination. Mrs. —— stated that she was not informed that she could submit additional medical evidence from other doctors and is not aware of the district office obtaining any other evidence on her behalf from other sources.

Mrs. ———, after receiving her denial letter, felt that she needed additional assistance in preparing her claim and contacted her "local politician" without any success, in an effort to obtain such aid. She stated that the denial letter she received from Social Security did not sufficiently explain the reason her case was denied and, consequently, she sought a further explanation from the district office. The applicant indicated that the district office representative, without informing her of the right to submit additional medical evidence, explained the rules and guidelines for making disability determinations and told her that he thought any appeal on her part would not do her any good. Mrs. ———, while understanding the reason why her claim was denied, requested a hearing in person because she did not believe it was the intention of the law to deny benefits to a person unable to obtain permanent employment because of a disabling condition.

Mrs. ———, after requesting the hearing, was sent by the State vocational rehabilitation agency to Dr. ——— for a medical examination. She stated she received a very thorough examination and that the doctor was very courteous.

Mrs. ——— stated she was not told she could have a lawyer or someone else represent her at the hearing but, at the suggestion of the district office representative, brought one of her neighbors to the hearing. Mrs. ——— stated that her neighbor had once found her lying unconscious on the floor of her apartment and offered to testify to that effect on her behalf.

Mrs. ——— stated that the referee was very courteous and she believes he correctly decided her case based on the limitations of the law. She stated that she was not informed that she had the right to appeal her case to the Appeals Council in Washington, nor in the event of further dissatisfaction, the right to take her case to the U.S. courts.

Mrs. ———, throughout the interview, questioned the effectiveness of a program which does not pay benefits to people unable to get a job because of a disability.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I kept an appointment to interview Mr. ——— on January 6, 1960. Mr. ——— sat in a chair for the interview and appeared to be under a physical strain. He seemed most appreciative that I came and insisted on telling me his complete story even though I offered to curtail the interview if it was tiring him. The applicant 60 years old, lives with his wife, three children of school age, and his wife's mother in their own home. The house was neat, clean, and comfortably furnished. Prior to 1944 Mr. ——— worked for a gas distributing firm, doing welding, general construction, and some service work. He then ran his own blacksmith and machine shop from 1944 until July 1956 when he had a heart attack. He reported he has had three milder ones since then. The second attack occurred after he went back to light work in his shop for 2 weeks in March 1958. He was forced to sell the shop in May of that year because he

could not run it any longer. His doctor has forbidden him to do any more work or to engage in physical exercise of any consequence. He drives his car only up town and back—three or four blocks. After he became ill, his wife went to work for a jet engine plant and worked there until she was laid off December 15, 1959. He reported that their only income at present is his wife's unemployment compensation. Information was furnished that he first filed his application for disability benefits June 13, 1957. This was disallowed March 5, 1958. A reconsideration of his claim was disallowed November 6, 1958. A hearing before the referee was held July 15, 1959, and benefits were denied as a result of this hearing by the referee's decision dated July 31, 1959.

Mr. ——— stated he found out about the disability program from the newspapers. He went to the district office where he was given an application and a medical report form and told to file them at the Social Security contact station near his home. He stated he had to wait 4 or 5 hours at the district office before someone talked to him. When he took his application and income tax returns to the contact station he had to wait only 30 or 45 minutes. He said he was treated courteously both places after he got to see the people. He reported that after he filed his application, Social Security representatives came out to see him two or three times to verify whether or not he was working. Mr. ——— then informed me that the disability program and his rights under it were not explained to him either at the district office or the contact station. The people he saw just asked him a bunch of questions and did not explain to him how disabled he had to be to qualify for benefits. Furthermore, they did not encourage or discourage him from filing.

Mr. ——— stated the only help he received from the contact station in filing was in helping him complete his application. He took the medical report form to his doctor, who mailed it in. He was not charged for its preparation but was charged for the doctor's examination, the same as for other office calls. At the request of Social Security, the applicant went to Dr. ——— for a consultative examination but did not have to take the doctor a report form. Mr. ——— did not feel this doctor gave him a thorough examination like other doctors did. He said his nurse did most of it. Furthermore, the applicant stated he was asked to walk up and down some steps 15 times. He could only walk up and down them 4 or 5 times and then collapsed and fell off of them. Mr. ——— stated he thought that doctors' declaring a person disabled was sufficient, and he did not feel he needed additional assistance in preparing his claim, after talking to the Social Security people, and did not obtain any.

The denial letter Mr. ——— received from Social Security did not satisfy him as to the reason his claim was denied, so he went to the Social Security contact station and asked for a hearing. He had to wait 1 or 1½ hours this time for someone to talk to him. He did not ask the representative the reason his claim was disallowed as he had already had his second heart attack. He filed for a hearing before the referee. His denial letter told him he could do this. He did not remember if he was told he could submit additional medical evidence. The contact station representative did not encourage or discourage him from appealing but prepared his request. Social Security did

not help him get more proof of his disability. Nevertheless, after he did not hear anything of his appeal for a long time and in order to get another doctor's opinion, Mr. — went to another doctor on July 2, 1959, for an examination. This doctor sent Social Security a narrative medical report in which he stated the patient was permanently disabled and advised him not to do any type of physical work in the future. The letter notifying Mr. — of his hearing stated that he could have someone represent him but did not indicate it could be a lawyer. His wife went to the hearing as his representative because he was sick in bed and unable to go at the time. The hearing notice did not tell him he had a choice of an "in person" hearing or a hearing based on the record. The notice merely stated for him to appear or his wife to appear for him.

Mr. — was not satisfied that he got a fair hearing of his case by the referee and did not believe his decision was correct. He explained that statements cited in the referee's decision as being from reports of contact of Social Security representatives who visited him to see if he was working while disabled misrepresented the facts, and he felt the referee was influenced by these misrepresentations of fact. He said one of the representatives already had his mind made up when he came to see him and told him he wasn't going to get any benefits. He also felt that some of the statements contained in the referee's decision that were supposed to have been made by his wife were false statements which his wife did not make. He stated that he did not feel his wife was treated courteously by the referee in that the referee interrogated her and inferred she was lying at the hearing by asking her such questions as, "How do you know if your husband is not working when you are working?" The applicant has not asked the Appeals Council in Washington to review his case because he did not know he could do this. He was never informed of this right nor of his right to take his case to the U.S. courts. He stated there was no letter of transmittal with the copy of the referee's decision he received and in hurriedly scanning the decision I could not see where he had been informed of the foregoing rights as to future action. Mr. — felt like he had received a rough deal on his claim.

Mr. — said he had paid social security taxes since social security had been in effect, with the exception of the years 1944 to 1951 when self-employment was not covered, and felt like this was the type of thing he was paying for. Now when he needed it, he felt it was unfair for him not to receive it.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

Mrs. — was interviewed in her apartment on January 4, 1960. She said she found out about the disability program from a newspaper and after inquiry, she went to the Social Security district office.

The applicant said that she did not wait long for someone at the district office to consider her case and that she was treated courteously. She said the disability program and her rights under it were fully

explained to her. The applicant said the Social Security representative neither encouraged nor discouraged her from filing a claim but gave her the information she requested. She said the district office did not help her in preparing her case and she received no other assistance. She obtained her medical proofs from her doctor after taking the medical report form to him. The doctor made no charge for its preparation. The applicant said the doctor examined her at the time but made no charge for his services. She said she also took a form to another doctor but she did not know whether social security obtained additional reports on her case.

Mrs. ——— said that after she first talked to the district office, she felt she needed additional assistance in preparing her claim, and that she received such assistance from her doctors. The claimant had no other comments to make about her treatment by the Social Security district office.

She said she talked to the district office representative after receiving the denial notice and was satisfied as to the reason her claim was denied. She was informed that she would have to be totally disabled to qualify but that she could appeal her case by submitting additional medical evidence. She said the district office representative maintained a neutral attitude with regard to an appeal.

Mrs. ——— said she received no help from the Social Security district office in getting more proof of her disability after she requested a hearing and that she received no help from anyone else. The applicant said she was not told she could have a lawyer or some one else to represent her at the hearing. Mrs. ——— said she was told that she had a choice of having a personal hearing before a referee or of having the referee decide her case on the papers that were in the record but that she was not encouraged to do either.

Mrs. ——— said that she is satisfied that she got a fair hearing of her case, that she was treated courteously by the referee, and that his decision was correct. She said that she was informed that she could take her case to the U.S. courts.

Mrs. ——— said she is presently not working but receives \$103 monthly from the welfare department.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I kept an appointment with Mr. ——— on December 28, 1959. This 53-year-old applicant lives alone at the motel. It is clearly apparent that the applicant is in extremely poor health. His body and limbs are severely emaciated and he moved slowly and with evident effort. He told me that he had suffered at least two strokes over the past 5 years, had not worked at all in that time and had been in the hospital. He appeared rational enough but he seemed to find it difficult to concentrate on the questions asked him. He was quite vague about time intervals and the number of visits, etc., to the Social Security district office. He told me that he is now unable to go outside the door. When he was able to go outside, which he said was about a year ago, walking was a strain and getting "worse all

the time." Mr. ——— said that at no time had any Social Security representative called on him.

He did not know exactly how he first found out about the disability program. He said that during his visits at the district office he was courteously treated, received a full explanation of the program and his rights under it and was told how disabled he would have to be to qualify for benefits. He told me that he had not been encouraged or discouraged about filing but that the Social Security representative had given him the information necessary for him to decide himself.

The applicant said that the Social Security representative had helped prepare his application. He said that he had to take medical forms to two different doctors. The applicant stated that both doctors had examined him and that neither one of them charged him for medical services. Mr. ——— said that he had no other comments on his treatment by the district office. He said, "They treated me all right."

Mr. ——— seemed to have difficulty remembering about a denial letter and proceedings. Mr. ——— told me that as soon as he knew he had been turned down he retained a lawyer to represent him at a hearing. The following quotation is from page 4 of the referee's decision:

"But the medical findings herein do not give a picture of a man disabled from pursuing any type of gainful occupation."

I asked the appellant what he or his lawyer intended to do next. He said, "I guess we can do nothing at all. Anyhow even if they did change their minds I guess I couldn't get the money in time for it to do me any good."

Mr. ——— physical condition and his behavior during this interview forced me to conclude that Dr. ——— remark "I don't believe this man will ever see 1961" was an understatement.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I interviewed the applicant in the afternoon of December 18, 1959. Mr. ———, age 62, lives with his wife and three children of school age in their own home which was neat, clean, and adequately furnished. Mrs. ——— sat in on the interview and participated in some of the discussions. Both the applicant and his wife were very cooperative and pleasant. Mr. ——— sat in a chair for the interview. He was thin and didn't look very strong. He stated he worked as a janitor at a defense plant about 20 miles from his home, for 9 years until in October 1957. He left his job on account of blood clots resulting from a skull fracture caused by an auto accident. He further stated that two-thirds of his stomach was removed on account of ulcers. He also reported that he has had asthma for years and this condition has become worse. He informed me he had just gotten out of the Veterans' Administration hospital on December 15 where he went because of nervousness. He stated he would get sick after eating. He asserted he cannot walk to any extent, suffers from stomach trouble from time to time, is weak and bothered with dizziness. He also

stated that extremes in temperature aggravate his condition. He receives a disability pension of \$66.15 per month from the Veterans' Administration as a result of service in World War I. This is their only income. Mrs. ——— does not work, as she feels she is needed at home to rear her children. The applicant obtained a disability freeze of his wages effective November 1, 1957, and first applied for benefits May 1, 1958.

Mr. ——— found out about the disability program from his co-workers at the defense plant and went to the district office. He knew where to go, as he had obtained his social security card from there. A Social Security representative never did come out to see him, since he always was able to go to the district office. He only had to wait about 30 minutes for someone to talk to him when he went to the district office to file his claim and was treated courteously. He stated, however, that neither the disability program nor his rights under it were fully explained to him. The district office also did not describe how disabled he had to be to qualify for benefits. The district office people neither encouraged nor discouraged him from filing but left it up to him.

Mr. ——— stated he filled out his own application and the only help the district office gave him in filing was to tell him what proofs to obtain. He took the medical report form to his doctor, who since has moved out of the State. The doctor did not charge him for preparing the report but did charge him \$3 or \$4 for an office call for examining him. He also took the report form to two other doctors who had treated him for various ailments. Moreover, he believes the district office obtained medical reports from the Veterans' Administration hospital. The applicant did not feel he needed additional assistance in preparing his claim, after first talking to the district office, and did not obtain any.

The denial letter Mr. ——— received from Social Security did not satisfy him as to the reason his claim was denied, so he requested a reconsideration and later a hearing by the referee. He was told he could appeal his case, and he did not bother to request an explanation of why his claim was disallowed. He was not informed that he could submit additional medical evidence, but on his initiative he had his doctor write a letter to Social Security. The district office representative did not encourage or discourage him from appealing but merely told him it was his privilege. The applicant did not get help from anyone else other than his doctor. He was told he could have a lawyer or someone else represent him at the hearing, but he did not think he should need anybody for this purpose and did not obtain anyone. Mr. ——— could not recall being given the privilege of an "in person" hearing by the referee and did not appear before him. He said he would have been only too glad to go had he known he could.

Mr. ——— stated he was not satisfied that he got a fair hearing of his case by the referee because he believed the referee's decision in denying him benefits was incorrect. He felt the decision was incorrect because he cannot work and his doctor has advised him not to work. He was informed of his right to ask for a review of his case by the Appeals Council in Washington and of his right, if still not satisfied, to take his case to the U.S. courts. He requested a review by the appeals council on August 3, 1959.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I met Mr. ———, his wife and two small daughters on December 17, 1959. Mr. ——— lives with his family on the sixth floor of a walk-up apartment building. He speaks Italian but understands and speaks little English. His wife and daughter acted as interpreters whenever Mr. ——— had trouble understanding the question. He claimed that he could not work. He also mentioned that he had arthritis which bothered him considerably especially when the weather was bad. He receives a veterans' nonservice disability pension amounting to \$66.15 a month and in addition he stated that he receives welfare aid of approximately \$107 a month.

The applicant found out about the disability program through friends and the welfare department. A sign in the neighborhood post office told him the location of his Social Security district office. He was accompanied by his wife when he went to the district office and they waited about 10 minutes before speaking to the Social Security representative. They were treated courteously on this first visit. On later visits, they stated that some people treated them courteously and some discourteously.

On their initial visit, the representative explained the disability program and his rights under it. The representative tried to explain to Mr. ——— and his wife how disabled he had to be to receive benefits but they did not understand him. He received a booklet from the representative which gave him information about the disability program. The representative encouraged him to file an application.

The representative filled out his application for disability benefits. Mr. ——— mailed a medical report form to a hospital and requested that they return it to the Social Security district office. He was not given a medical examination or charged for the preparation of the medical report form. The applicant did not take or mail a report form to any doctor.

Mr. ——— was sent to be examined by Dr. ———. The doctor treated him courteously and gave him a good examination. He was not charged for the examination or report.

Mr. ——— did not feel that he needed additional assistance in preparing his claim. He had no other general comments to make about treatment by the district office except that he felt that he and his wife should have been treated courteously on all visits.

The applicant was not satisfied with the denial letter sent to him by Social Security explaining why his claim was denied. When he asked the Social Security representative why he had been denied he was told that he was not disabled enough to receive benefits. He understood the representative but he did not agree with him. The representative told him that he could appeal his case and submit additional medical evidence to support his claim. The representative did not express any opinion about his case. He just accepted the applicant's application for an appeal. The district office did not help Mr. ——— get more proofs of his disability nor did he receive help from anyone else.

The applicant was not told that he could have a lawyer or someone else represent him at the hearing. He was told that he had a choice of having a personal hearing before a referee or of having the referee

decide his case on the papers that were in the record. He was encouraged to be present at the hearing as he could present his claim better in person.

Mr. ——— believes that he got a fair hearing of his case. The referee treated him courteously during the hearing. He was not satisfied with the decision. So he has requested the Appeals Council to review his case. He felt that since he cannot work he should be entitled to some benefits. He did not know that he could also take his case to the courts. He has not yet received any answer on his appeal.

I thanked them for their cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I kept an appointment with Mrs. ——— on December 29, 1959. The applicant is 55 years old and lives with two of her sisters in an attractive one-family home. Mrs. ——— worked for about 21 years prior to 1958. The company is currently paying the applicant a disability pension of \$75 a month. She said that the company doctors had examined her and determined that she was physically unfit for either whole or part-time employment by the company. She stated that the company had told her that she would be reemployed by them, possibly on a part-time basis, if her physical condition improved sufficiently to make it feasible for the company to do so.

Mrs. ——— said that she went to the district office of Social Security at the direct suggestion of a personnel department official of her company. She stated that she had made only one visit in person and that subsequently a district office field representative had visited her twice.

The applicant stated that on her first visit to the district office she did not have to wait before someone talked to her; she was treated courteously and asked to sign a simple form; she was told that a field representative would be sent to see her. She said she had received little explanation about the disability program and her rights under it. She stated that a female representative told her that if she was able to take care of herself completely it is not likely that she could qualify for disability benefits. The applicant said the field representative who visited her gave her very complete information and explanation. She said that the field representative, on his first visit at her home, had asked her the questions necessary to complete the application and other papers. The applicant said that the representative did or said nothing that would tend to discourage or to encourage her about filing. She said that she had made up her own mind to file a claim and had given great weight to the opinions of the company doctors and of her own family physician.

The applicant stated that her medical reports had been submitted by three doctors.

I asked Mrs. ——— about her experience with the district office in connection with the denial of her claim for disability benefits. The applicant said that the district office representative had fully informed her about her rights to: (1) Make further appeal; (2) retain a lawyer to represent her; and (3) supply additional medical evidence.

Mrs. ——— said she believes that she now understands exactly what the situation is but that she will do nothing further about it although

she is not satisfied. She said that she fully expected to get an \$88 a month disability benefit. She commented that if she had qualified for this amount her company would have offset one-half the amount against the \$75 pension that the company is now paying her.

I asked the applicant to tell me why she decided to take no further action on her claim and she said:

How can I hire a lawyer when I have an income of only \$75 a month? Anyhow, I suppose the decision is correct according to the social security law and nothing could be done to change it. I have already given Social Security all the information I have now, or can get for them.

If I had to go again to doctors and elsewhere in order to accumulate information for Social Security, I know it would be nerve-wracking and very upsetting. It would be very bad for my high blood pressure and hypertension. Besides this it would be expensive because my brother would have to take time off from his job to transport me from place to place. I don't think I would be justified in making my bad condition worse.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I kept an appointment to interview the applicant on December 18, 1959. Mr. ———, who is 59 years old, lives with his wife in their home on the outskirts of a small town. The house was neat and clean on the inside and contained considerable furniture for its size. The applicant walked and moved about fairly well. He said his disability consisted of ulcers and arthritis. He stated he worked for a construction company off and on as a laborer (carpenter's helper and concrete man) for 12 or 15 years until he got sick in April 1956. He asserted he always worked hard and never shirked his duties for his employer. He showed me a letter dated September 11, 1959, from his union certifying as to his sincerity and honesty. He stated he did not believe he could work now even a few hours a day. He informed me their only means of support was from a small rental house on the rear of their home property and from his wife working.

Mr. ——— found out about the disability program from his wife who read about it in the newspaper. His wife first went to the Social Security contact station and got information. He then went and filed his claim. He said the Social Security representative came out to see him once. He stated he only had to wait about one-half hour at the contact station for someone to talk to him and was treated courteously. He further stated flatly that the disability program was not fully explained to him, but his memory seemed a little hazy as to whether his rights under it also were not fully explained to him. He asserted that the Social Security representative did not tell him how disabled he had to be to qualify for benefits. He stated that the Social Security representative encouraged him to file an application.

Mr. ——— stated that the only help he received in filing consisted of the Social Security representative filling out his application for him to sign. The applicant took his medical report form to his

doctor. He was not charged for preparation of the report, but the doctor charged him \$3 for the examination. He did not take or mail the report form to other doctors. His doctor, however, sent him to a medical center for an examination, and he believes the center sent a report to Social Security. After he first talked to the Social Security representative, he felt he needed additional assistance in preparing his claim but didn't obtain any.

The denial letter Mr. ——— received from Social Security did not satisfy him as to the reason his claim was denied, and he stated he refiled March 4, 1959. From his other remarks and from evidence at hand, however, I believe he meant he requested a hearing. Although the applicant was uncertain as to whether he had obtained a reconsideration of his claim prior to the request for a hearing, information that he furnished indicated he had. The applicant indicated he had been called to the district office to file for the reconsideration. He stated he had to wait there 1½ hours for someone to talk to him, but was treated courteously. He further stated he was directed to obtain a consultative examination from Dr. ———. The Social Security representative told him when he requested a hearing that the reason his claim had been disallowed was that he would have to be so disabled he would be confined to his bed and never be able to get out of bed again. However, he was informed that he could appeal his case and could submit additional medical evidence. The representative was also very willing to appeal the applicant's case. Social Security did not help him get more proof of his disability nor did he get help from anyone else. He was told he could have a lawyer or someone else to represent him at the hearing, but he didn't have anyone because he didn't feel he could afford it. Mr. ——— did not remember for certain if he was told he had a choice between an in person hearing or a hearing based on the record, but he said it didn't matter since he preferred to go down and talk to the referee and did so.

Mr. ——— stated the referee was very nice but he did not think the referee's decision was correct. The Social Security representative told him he could appeal his case further, but it wouldn't do him any good because he would have to be flat on his back to get benefits. A lawyer, recommended by his union, also told him it wouldn't do him any good to appeal and he just would be wasting his time. The lawyer made no charge for his advice. These comments by the Social Security representative and the lawyer are the reason he has taken no further action on his claim.

Mr. ——— stated again that he could not work and therefore felt he should receive benefits. He said his doctor told him he had patients in better shape than he was who were getting disability benefits and he couldn't understand why he was not entitled to benefits.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I contacted Mr. ——— by mail and arranged to see him on December 29, 1959. He lives with his friend, a retired longshoreman. They have an apartment on the third floor in a four-family walk-up building. The building is in a clean neighborhood a block from a

shopping section. He stated that he was 60 years old and, since his accident, he has been unable to work at his former occupation as a longshoreman. He walked slowly and stated that he can't lift heavy items any more. He said that he would answer my questions as accurately as he could.

Mr. ——— first heard about the disability program from the International Longshoreman's Association which also told him the location of his district office. He went to the district office where they treated him courteously and discussed his case with him about 10 minutes after his arrival. Social Security personnel explained the disability program and his rights under it to him but the representative did not describe how disabled he had to be to qualify for benefits. The Social Security representative encouraged him to file an application.

The representative filled out the application for him. He obtained his medical proofs from his doctor and a hospital. He was not sure if he mailed or took the medical report forms to his doctor and the hospital. He was examined by Dr. ——— at this time but not by the hospital. He was not charged for the examination or for the preparation of any medical reports. He stated that he did not take or mail a report form to any other doctor. Mr. ——— believed that the district office also obtained reports on his case from the Workmen's Compensation Office.

Mr. ——— stated that he was sent to Dr. ——— for an examination. He said that the doctor made him wait until all his other patients were treated and then examined him. He was well satisfied with the examination. He said that it was very thorough and took 2½ hours to complete.

Mr. ——— felt that he needed no additional assistance in preparing his claim after his initial visit to the district office. He did not comment further on his treatment by the Social Security district office.

Mr. ——— stated that he never received a letter from Social Security telling him that his claim was denied; he believed that the letter was lost in the mail. When he inquired about his claim at the Social Security district office they told him that he had been denied. A Social Security representative read the denial form letter to him and told him of his right to appeal. The representative also told him that his claim was denied because one of the doctors who examined him stated that he could work 6 hours a day as other than a longshoreman. He understood this and he was also told that he could submit additional evidence to support his claim.

The representative encouraged him to appeal his case. He appealed his case immediately. The district office did not help Mr. ——— get additional evidence to support his claim. He was told, however, that he could have a lawyer represent him at the hearing and he retained a lawyer to represent him. He felt that a lawyer could present his case better before the Hearing Referee. He had not yet been charged for this representation and he did not know if the lawyer was going to charge him. Mr. ——— was told by the Social Security representative that he could appear before the referee in person or have his case decided from the papers in his folder. He was not encouraged to do either. He decided to appear in person and be represented by his lawyer.

Mr. ——— stated that he received a fair hearing and that the referee treated him courteously. However, he was not satisfied with the decision. He felt that he should have been awarded a benefit. Mr. ——— did not know that he could have asked the Appeals Council in Washington to review his case. He did know that he could take his case to the courts. Mr. ——— does not think that he will take his case to the courts. He felt that it would be expensive and that the court would probably agree with the referee. He intended to talk to his lawyer before taking any further action. Mr. ——— is not presently working.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I interviewed Mr. ——— at his home on December 22, 1959. He resides in an older section of the city with a brother and sister-in-law. He is 54 years of age and said he feels it keenly that he is unable to work or contribute to his own upkeep. He originally filed his application with the district office in August 1958. The application was denied in December 1958. Mr. ——— appealed for a hearing on the denial. The hearing was held April 21, 1959, and the claim was again denied in letter of July 27, 1959, from the referee. The applicant said it was about 3 months from the date of his appeal until the date set for the hearing. He appeared to be sincere and his statements credible. He is thin, anemic, has trouble breathing, and he said he is losing weight and has no money for medicines prescribed by the doctor. He has not worked since April 1, 1958, when he left the shoe company, where he had been employed from 1936 to 1951. The company explained the disability plan to all employees, and he located the Social Security office from the telephone book. No Social Security representative came out to see him. He had to wait about 15 minutes on his first trip to the Social Security office, was treated courteously, and he believed his rights fully explained to him. He was advised the doctor's medical report would be the basis of qualification, and the Social Security office did not influence him to file or not to file.

Mr. ——— stated that the application was filled in by the Social Security employee from the applicant's answers to the questions. He explained there were five medical reports in all; one from his personal physician at the time, three from doctors who had treated him previously, and one from a doctor to whom he was sent by the State Vocational Rehabilitation agency. He remarked that he took the medical report form to two of the five doctors but it was apparently mailed to the other three by the Social Security or the State agency. He said they all charged for the reports, except the State agency doctor and he still owes them. He knew of no other reports obtained by the district office. He added he had worked at a bottling company for approximately 7 years prior to his doctor advising a change of climate and complete rest. He said after he had talked to the district office, he did not feel the need of additional assistance, and did not get any from any other source. He had no other comment on his treatment by the district office.

The letter Mr. ——— received from Social Security denying his claim did not satisfy him as to the reason for denial. He went to the district office for advice. He said, "They were not interested," but he requested reconsideration of his case. Apparently the district office did not discuss the hearing or advise him that he could have legal representation. He said the next thing he heard from them was the notice of the hearing.

The hearing was held on April 21, 1959, and the applicant said the decision was apparently based on what the referee read of reports on file. He was not asked for additional proof of disability. He stated the hearing lasted only 30 minutes, and he was not advised of any further right of action in the courts but believed this decision was final. The applicant stated the referee commented on his apparently normal breathing, and lack of pain during the hearing. He further stated it was his opinion that the denial was on this basis rather than the medical reports. He added he did not believe the referee competent to make such a determination of his disability in a 30-minute period.

Mr. ——— added that after denial by the referee the Social Security office called and suggested he see the counselor for the State vocational rehabilitation service, which he did. He was advised by the counselor that the State could furnish artificial limbs or glasses for him. He told the counselor he did not need either of the items offered, but could use the money for medicine prescribed and other expense. At the time of my interview he had taken no further action due to ignorance of his rights but said he will try to arrange for representation to take the case to the U.S. courts. Mr. ——— was grateful for this information.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Allowed After Hearing

I interviewed Mr. ——— in his home on December 22, 1959. He is 51 years old and lives with his wife, a daughter, and a son in a frame house off a rural road. He is a thin, frail looking man who appears ill. He stated that he has third degree anthrasicosis accompanied by emphysema. He tires very easily and spends most of his time resting. At the outset of the interview Mrs. ———, who dominated their part of the interview, evaded my questions and began to complain of the trouble and hardship that Social Security caused her husband. She complained about the length of time it took Social Security to process her husband's claim and the additional cost that they incurred in order to be represented at the hearing. She continued in this manner for some time. It was not until she left the room in search of certain records that I was able to speak with Mr. ——— who was soft spoken and understanding. In her absence Mr. ——— told me that his claim was allowed in September 1959 approximately 13 months after he filed his application. I explained to them that this interview would not affect their claim in any way; this statement seemed to put Mrs. ——— at ease.

Mr. ——— stated that he worked for a coal company until the early part of 1957. He was advised at that time by his physician to leave

the mines and obtain outdoor employment. He got a job as a time-keeper for a contractor. Although it was easy work, he did not have the physical stamina to do a full day's work. He then took a job as a porter. He said the job was not too hard but that he became exhausted after only a few hours work each day. He was advised by his doctor to return home and rest. He has not worked since then.

In September 1957, he applied for workmen's compensation and after having a hearing on his case his claim was approved in April 1958. He is presently receiving a pension of \$130 a month.

Dr. ———, who had examined Mr. ——— and submitted medical evidence for his workman's compensation claim, suggested that he apply for social security disability benefits. On the doctor's advice, Mr. ——— and his wife went to the district office, in August 1958 and filed a disability application. They did not have to wait long and were treated courteously. The claims representative read to them about the disability program and their rights under it. Mrs. ——— stated that at that time they felt they understood the information. Mr. ——— emphasized that the representative gave them a good description of the disability requirements. Based on this information they made their own decision to file.

The claims representative asked them a number of questions and completed the application. The medical report form was mailed to them at a later date. Mr. ——— took the medical report with him on his next regular visit to Dr. ———. He was given an examination and was charged the regular fee for the visit; he was not charged for the preparation of the report. Mr. ——— did not take or mail a report form to other doctors. At the request of the State agency he was given a general examination by another doctor. In addition, he went to a hospital for a chest X-ray and a cardiogram. Mr. ——— did not feel that he needed additional assistance in preparing his claim and did not receive such assistance from other persons or organizations. Mr. and Mrs. ——— commented that they were well pleased with the way they were treated by the district office; they stated that no Social Security representative came to visit them at any time.

Neither Mr. ——— nor his wife could remember the date they received the letter of denial but they believed that it was in March or April 1959. Mrs. ——— emphatically stated that they were not satisfied with the decision. She said that as far as she was concerned the letter did not give the reason why her husband's claim was denied. They visited Dr. ——— and discussed the decision. Mr. ——— said that the doctor seemed disturbed with the decision and told them to go back to the Social Security district office. They explained their problem to the claims representative at the district office, who seemed sympathetic and advised Mr. ——— to reopen his claim. The claims representative encouraged them to request a hearing. As a result of this advice, Mr. ——— initiated a request for a hearing.

On June 30, 1959, he was notified to appear in person for a hearing before the referee at the district office. The letter also advised Mr. ——— of his right to be represented at the hearing. The hearing was held in July 1959. Mr. ——— attended the hearing with his wife and his son. He was represented by Dr. ———. Mr. ——— stated that he felt he needed a doctor to argue his case. Dr. ——— charged him \$20 for his services.

Mr. ——— was notified that his claim was approved some time in early September 1959. Mr. ——— and his wife praised the referee for his courteous treatment and his fair review of the claim. They believed his decision to be correct. Mr. ——— stated that other than the considerable time involved in obtaining a favorable decision, he was satisfied with the way he was treated by the Social Security people.

I thanked them for their cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I arranged by telephone to see Mrs. ——— on December 29, 1959. She lives with her husband in their two-family house in a residential section of the city. Mrs. ——— and her daughter were present at the interview. Mrs. ——— stated that she was 54 years old and has a long wait before she can collect old-age benefits. She was formerly a sewing machine operator in a dress factory but because of her heart condition she is now unable to work. She stated that she cannot leave her house without a companion and she must always have her pills nearby in case of a sudden heart attack. Mrs. ——— stated that she now has a new family doctor. She showed us a letter signed by the doctor which stated that she was totally disabled from any gainful occupation. She intends to show this letter to a Social Security representative the next time she sees one. Mrs. ——— and her daughter were very cooperative during the interview.

Mrs. ——— heard about the disability program from her nephew. She went to a Social Security district office and filed an application. She was treated courteously after waiting about 15 minutes. A Social Security representative discussed her case with her and explained the disability program and her rights under it to her. However, this explanation was not complete and he did not describe how disabled she had to be to qualify for benefits. She was given a booklet and told to read it. The representative let her make her own decision to file an application for disability benefits. She had gone to the district office with intentions of filing such a claim and she did.

The representative filled out her application. She obtained her medical proofs from her family physician. She mailed him the medical report form and he filled it out. She was not charged for the report. She did not take or mail a report form to any other doctor.

The State agency sent Mrs. ——— to another doctor for an examination. She stated that he was polite and she was satisfied with his examination. There was no charge for the examination or any medical report.

Mrs. ——— did not feel that she needed additional assistance in preparing her claim after her initial visit to the Social Security district office. She made no general comment on her treatment by the district office.

Mrs. ——— was not satisfied with the explanation she received when her claim was denied. She said that the letter did not state the reason she was denied so she took it to her Social Security district office. She stated that the representative at the district office could not help her understand the basis for denial. She was told that she could

appeal her case and she was informed that she could submit additional medical evidence to support her claim. The representative made no comments about her claim. She then appealed the claim.

Mrs. ——— said that she received no help from anyone in securing more proof of her disability. She also stated that she did not know that she could have had a lawyer represent her at the hearing. If she had known this, a lawyer friend would have represented her. Mrs. ——— stated that she was told by the district office that she had to appear before the referee, and if she was unable to appear at the designated place, the referee would hold the hearing in her home. Social Security set a place for the hearing and she appeared in person before the referee.

Mrs. ——— was well satisfied with the referee and the hearing. However, she was not satisfied with the decision. She felt that she should have received a disability benefit. She knew she could have the appeal reviewed and she requested this review. Mrs. ——— knew that if she is denied the benefit at this review, she can take her case to the U.S. courts. She wasn't sure whether she would go any further with her claim. She felt that it would be too expensive to take her case to a U.S. court. She stated that she would talk to a Social Security representative before taking any further action. Mrs. ——— is not presently working.

I thanked them for their cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I interviewed Mrs. ——— in her home on December 22, 1959. She lives in a small frame house with her husband and an unmarried daughter, age 32, who provides the main support of the family. Mrs. ———, who is 51 years old, is a heavy set, gray-haired woman with a fair complexion. She wore glasses, talked well, moved about without any apparent difficulty during the interview and seemed to understand my questions. I saw no apparent physical impairments and from her general appearance, she looked healthy. She explained that she had a severe arthritic condition that extended from her shoulders down to her hands. She showed me her fingers and demonstrated how difficult it was for her to move them. She said her arms pained her constantly and that it was a great effort to move them; she stated that at night she could hardly sleep because of the pain. She added that her daughter did most of the housecleaning and that her husband, who is retired, did most of the cooking. She said that she had worked as a machine operator for a dress factory but had to stop working because of her arthritic condition. Her physician, who had been treating her regularly, advised her to cease working. She could not remember the specific date that she terminated her employment but estimated it to be in the early part of 1957. Mrs. ——— and her husband are presently living on his Social Security old-age monthly benefit of \$68 and on the financial support provided by their daughter. He emphasized that without the financial help of his daughter, who is making a personal sacrifice in providing the help, he and his wife would not be able to make ends meet.

When I began the interview with Mrs. ——— and her husband, who spoke broken but understandable English, I found they did not have a good recollection of the facts surrounding her claim.

Mrs. ——— had a hearing and her claim was denied. Approximately 18 months had elapsed from the date Mrs. ——— filed to the date she received the referee's adverse decision.

Mr. ——— stated that 2 years ago, at age 63, he applied for disability because of a heart condition and his claim was allowed quickly and without any trouble. Upon his reaching age 65 his disability benefits were converted to old-age benefits. In the light of this experience he could not understand why it took so much time to process his wife's claim, especially since it was denied. He stated that if his wife were able to work she would be making about \$40 to \$50 a week. He seemed to reason that the very fact that she could not work was sufficient to qualify her for benefits. He believed that Social Security, in making its final determination, should have taken into consideration (1) his wife's incapacity to continue her employment, and (2) their small income.

Mrs. ——— stated that she knew about the disability program and where to apply from her husband's experiences with the program and from reading the newspapers. In March 1958, she and her husband went to a contact station at the Post Office Building and filed an application for disability. She said that they did not wait long and that the field representative at the contact station treated them courteously. At first she said that the disability program and her rights under it were explained to her but she later qualified this statement by saying that she was not sure; she further stated that she believed that the field representative did not describe to her the medical requirements for disability. She said the field representative gave her general information on the program and she decided to file. The field representative asked her questions and completed the application. Sometime later, she received through the mail a medical report form which she took to her doctor. The doctor gave her an examination and charged her \$4 for it. He did not charge her for the preparation of the medical report. After some deliberation with her husband, she said that she believed she was examined by a Social Security doctor but could not remember his name or the type of examination he gave her. She did not know if the district office obtained reports on her claim from other sources. She said that she did not feel that she needed additional assistance in preparing her claim and that she received no assistance from other persons or organizations.

Mrs. ——— showed me her first denial letter, dated February 16, 1959, and emphatically stated that it did not satisfy her as to the reason her claim was denied. She took the letter to the contact station where she had originally applied for disability benefits and showed the letter to the field representative; he could not give her an adequate explanation of the reason the claim was denied. The field representative advised her to go to the district office and discuss her claim with one of the representatives there. She said the district office people could not give her a specific reason for her denial except that she had been determined to be capable of being gainfully employed. She was told of her right to appeal the decision. She then went to her lawyer who recommended that she request a hearing. She said that to the best of her knowledge Social Security did not obtain additional

medical evidence on her case for the hearing. She said that the denial letter had informed her of her right to be represented at the hearing. She was advised by post card from the district office to appear in person before the referee on August 11, 1959. Mrs. ——— attended the hearing with her husband and was represented by Dr. ——— and her attorney. Neither one charged her for his representation.

Mrs. ——— stated that although she was treated courteously by the referee, she did not believe his decision was correct. She showed me the copy of the referee's decision and the attached transmittal letter from the Social Security Baltimore Office. I noticed that the transmittal letter stated that a request for review of the referee's decision by the Appeals Council must be initiated by the claimant within 60 days from date of receipt of the letter. The 60-day period had elapsed a few weeks prior to this interview. I asked Mrs. ——— why she did not request the Appeals Council to review her case. She expressed surprise and stated that she was not aware of this privilege. She explained that she showed her attorney the letter and he advised that she could appeal but he discouraged her from doing so. Her lawyer stated that appeals usually were costly and time consuming and that there were no guarantees that their efforts would result in a favorable decision. Mr. ——— said that he could not afford the cost of appealing the case so he accepted the advice of the attorney. Mr. ——— said that he was going to discuss his wife's case with his Congressman.

I thanked them for their cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I interviewed Mr. ——— age 62, at his residence on December 29, 1959. He stated that they owned the house and were attempting to sell it. They were borrowing money to live on until the sale of the home. He said he filed his application for Social Security disability on October 28, 1958. After a reconsideration of his claim a hearing was held on August 13, 1959. He asked for review by the Appeals Council on August 28, 1959, and received denial from them on November 13, 1959. Mr. ——— insisted he cannot get a job to support himself due to his disability.

He found out about the disability program from various sources and said friends told him he should file. He made application at a Social Security contact station. He said he waited about 30 minutes to see the Social Security representative and that he was very courteous. His rights were explained to him and he was told he would have to be totally disabled to qualify. He stated he was encouraged to file, and the representative filled out the form but didn't give out much information.

Mr. ——— stated that after filling out his application the representative gave him medical report forms which he delivered to two doctors. He said his doctor ordered him to a hospital for 5 days, and if he was charged for examination or preparation of the medical reports it was in the hospital bill. He knew of no other reports obtained by the Social Security Office. He did not feel the need of additional assistance after talking to the Social Security Office and did not at-

tempt to obtain any. He had no additional comments on his treatment by the Social Security office.

As to the denial on original application, Mr. ——— said he was not satisfied with the district office reason for denial. He said he knew of his rights from his original visit and took the steps necessary to appeal his claim. He had no legal representation at the hearing and although he was not encouraged to do so, he appeared in person at the hearing.

He stated that although he thought he had a fair hearing before the referee he appealed his decision to the Appeals Council. He knew he could go to the U.S. courts, but didn't believe he would take further action.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

On December 14, 1959, the applicant was interviewed at the hotel where he lives alone. While he appeared to be slightly feeble, otherwise he appeared healthy. He answered all questions and appeared to be mentally alert.

The applicant said he found out about the disability program from a friend, who told him he should apply for social security disability benefits. He then went to the Social Security district office. He said that he was treated very courteously there. He did not have to wait long before someone talked to him. Mr. ——— said the disability program and his rights under it were not fully explained to him but that the Social Security representative asked a lot of questions.

Mr. ——— said the Social Security representative neither encouraged nor discouraged him to file an application. He took the medical report form to his doctor to obtain his medical proofs. The applicant said that no charge was made for preparation of the report and that the doctor did not examine him at the time as his condition was well known to the doctor.

Mr. ——— said that he did not mail a report form to other doctors and did not know whether the Social Security district office obtained reports from other doctors, institutions or hospitals. The applicant said that he did not feel he needed additional assistance in preparing his claim.

Mr. ——— said that the letter he received from the Social Security office did not satisfy him as to the reason his claim was denied and that he filed for a hearing but did not talk to the Social Security district office at this time. Mr. ——— said that he did not go back to the Social Security district office and that they did not help him to get more proof of his disability neither did he get any help from anyone else. The applicant said he was not told he could have a lawyer or someone else to represent him at the hearing. He said he took no action in the matter of representation.

Mr. ——— said he was not told he had a choice of a personal hearing before a referee or of having the referee decide his case on the papers that were in the record. The applicant said he personally attended the hearing and was not satisfied that he got a fair hearing

of his case. He did not believe the referee's decision was correct. He said he was disgusted and did not ask the Appeal Council in Washington to review his case. The applicant said he was informed by the Social Security office that he could take his case to the U.S. courts.

Mr. ——— said he was not working at the present time but receives \$59.75 twice monthly from the welfare department.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I interviewed Mr. ——— in his home on December 23, 1959. Mr. ——— who will be 60 years old on January 16, 1960, lives with his wife in a one-story four-room modestly furnished house. He is a short, medium-built man with a ruddy complexion. He spoke broken English but could be easily understood. He explained that he has third degree anthrasicosis (miner's asthma) which has incapacitated him for work. He has been regularly treated for his asthma and also for a kidney ailment. As he talked I could hear him make wheezing noises in his breathing. He coughed sporadically during the interview. He emphasized that he wanted to work but that he becomes short winded when he engages in physical activity. He complained that at times his knees become stiff and this affected his mobility. I found him to be sincere. He answered my questions willingly and completely. He maintained good records on his claim and showed me a number of documents concerning it. He mentioned that upon receiving notice of our intended interview, he consulted Dr. ——— who advised him to cooperate fully with the interviewer. The doctor gave him a reproduced copy of the medical report to show to the General Accounting Office interviewer. It was a report of chest X-ray establishing the presence of anthrasicosis in the third degree.

Mr. ——— stated that he has been seeking social security disability benefits for approximately 15 months. During this period his claim was reviewed by a referee and denied, and his request for review of this decision by the Appeals Council was also denied.

He said that he worked for a coal company when he became incapacitated in November 1957. He applied for workmen's compensation at that time and his claim was approved in May 1958. He is now receiving a pension of \$130 a month. In addition to this income, his wife, who is 48 years old, is employed in a cafeteria.

Mr. ——— stated that he found out about the disability program and where to apply from other workers who had applied for disability benefits. On July 8, 1958, he went to the district office and filed his application. He stated that he did not have to wait long and was treated courteously by the district office people. He did not believe that the disability program and his rights under it were explained to him. The Social Security representative encouraged Mr. ——— to file for social security benefits.

The claims representative asked Mr. ——— a lot of questions and completed the application. He was given a copy of the medical report form which he immediately took to Dr. ———. The doctor did not examine Mr. ——— at that time because he had examined him the

day before. Dr. ——— completed the form but did not charge him for doing it. In addition, Dr. ——— submitted an X-ray of the applicant's chest. Mr. ——— did not take or mail a report to other doctors, and did not know if the district office obtained reports on his case from other sources. He stated that he was not examined by a Social Security doctor at that time. He felt that he did not need additional assistance in preparing his claim and did not receive assistance from other persons or organizations. He stated that he was treated well by the Social Security personnel.

He received his first denial letter, dated October 13, 1958, approximately 4 months from the date of filing his application. He stated that the denial letter was too general and that it did not explain the reason his claim was denied. He showed the letter to the claims representative at the district office who could not give him a satisfactory reason for the denial. The claims representative advised him of his right to request a hearing and encouraged him to take advantage of this right. On October 17, 1958, he initiated a request for a hearing. On March 16, 1959, he was notified to appear in person before the referee on April 3, 1959. This letter also advised him to bring medical witnesses or lay persons to testify on his behalf. Mr. ——— asked Dr. ——— to testify for him. Dr. ——— told Mr. ——— that he could handle it alone, and that he would be asked only a few questions. Mr. ——— said that he did not submit additional medical evidence for the hearing. He doubted whether Social Security had obtained additional evidence for the hearing. He attended the hearing without any representation. He stated that based on Dr. ——— statement, he did not feel he needed a lawyer.

On May 18, 1959, Mr. ——— received a letter from the referee stating that after hearing his case and examining the records it appeared desirable to obtain special medical examinations to show the extent of Mr. ——— impairment. The letter further stated that the hearings examiner requested the State agency to conduct further examinations. Shortly thereafter, he was notified to go to certain doctors for specific examinations. In June 1959, Mr. ——— was examined by Dr. ———, internist, and Dr. ———, an orthopedist. On July 13, 1959, he was advised by letter that the medical records of the two doctors had been received by the referee and would be used as evidence on his claim.

By letter dated August 4, 1959, Mr. ——— was notified that his claim was denied by the referee. The transmittal letter (attached to the referee's decision) stated that he could request the Appeals Council to review his case. On August 11, 1959, he submitted his request to the Appeals Council. On October 23, 1959, he was advised by letter from the Chairman of the Appeals Council that the Council had concurred with the referee's decision and had denied his appeal.

Mr. ——— seemed very disappointed about the outcome of his claim. He stated that he could not understand why he is considered disabled for State workmen's compensation purposes but not for social security disability. I asked him if he planned to appeal his case. He stated that it would be too costly to hire a lawyer and that he could not convince Social Security that he is unable to work. He indicated that he would wait until he became eligible for old-age benefits.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I interviewed Mrs. ——— at her home on December 29, 1959. Mrs. ———, who is 56, reported her doctor stated she is unable to work, and she has had no income since April 1957 when she left her job with a shoe company because of her heart condition. Her husband, age 60, works part time and earns about \$3.50 per day.

The applicant filed her claim in April 1958, at a Social Security contact station. After a reconsideration of her claim a hearing was held on March 2, 1959, and the notice of denial was dated August 31, 1959.

Mrs. ——— stated she had heard of the social security program through the local newspapers. She did not recall how long she was required to wait in filing her original application, but was treated courteously at the time. She added that she remembers this because of the change in the representative's attitude after her application had been denied. She could not recall any explanation being made to her of her rights under the program, nor how disabled she had to be to qualify. They did not advise her as to whether or not she should file.

The applicant stated that the representative filled out the application from her answers to his questions and she did not read it prior to signing it. She obtained original medical report from her family physician, and was also sent to a doctor by the State rehabilitation agency before the referee's hearing. Additional reports were furnished by two hospitals.

Mrs. ——— stated the letter of denial did not satisfy her since it did not adequately explain why her claim was denied. She stated she learned of the possibility of appeal for a hearing from friends, and stated the representative had not told her she could submit additional medical reports. She added that the Social Security representative was not as courteous after the original denial and had told her that her case was hopeless and it would be useless to appeal. She also said that the Social Security representative gave her no assistance after her request for a hearing, but her neighbors did what they could. She was told in the letter requesting her to appear at the hearing that she could have a lawyer or other representation at the hearing, but she did not have anyone represent her since she could not afford to pay any legal fees. She stated that the letter informing the applicant of the hearing did not differentiate as to "in person" appearance or a hearing based on evidence in the claims file.

Mrs. ——— stated she definitely does not agree with the referee's decision in denying her claim. She added that the referee was courteous at the proceedings. The referee's letter of denial advised her of her right to appeal to the Appeals Council in Washington or to file in the U.S. courts. She had not filed an appeal since she is discouraged because she has been turned down so often, the cost is prohibitive, and the result is doubtful. She stated that she was still considering seeking legal advice and carrying it to the courts if necessary, providing she can arrange the finances or credit.

I thanked her for her cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

The applicant was interviewed on December 16, 1956, at his home. He works for a hospital and earns \$2,900 gross per annum.

Mr. ——— thinks he learned about the disability program from the press. He does not recall whether someone told him where to go or whether a Social Security representative initially called on him. He said that he visited a Social Security office and that he did not wait long for someone to talk to him. He felt that he was treated very courteously. He said the disability program and his rights under it were not completely explained to him but that the Social Security representative verbally described how disabled he would have to be.

The applicant said he was neither encouraged nor discouraged from filing an application. He was given the necessary forms to file his claim; and he was also given various booklets describing the disability program. He said he got his medical proofs by signing some forms furnished by the Social Security office authorizing the release of medical information. The applicant did not recall whether he took these forms to the doctor or mailed them. Mr. ——— said he does not think the doctor charged him for preparing the medical report. He was not examined at the time. The applicant said he did not take or mail a report form to any other doctors. He does not know if the Social Security district office obtained other reports on his case from doctors or others.

Mr. ——— said he did not feel he needed additional assistance in filing his claim. The applicant said the letter he received from the Social Security office satisfied him as to the reason his claim was denied and he took no action. However he subsequently talked to the Social Security representative who informed him that the reason his claim was not allowed was that he was working. He said he understood the representative's explanation but he stated he was not working at that time. He was told that he could appeal his case by submitting additional medical evidence. The claimant does not recall the attitude of the Social Security district office concerning an appeal of his case.

Mr. ——— said the Social Security district office did not help him to obtain more proof of his disability and that he received no further help from anyone. The applicant said he was told that he could have a lawyer or someone else to represent him at the hearing but that he did not obtain anyone for this purpose. Mr. ——— said he decided he could not afford to have someone represent him. The applicant does not think he was told that he had a choice of having a personal hearing before a referee or of having the referee decide his case from the papers that were in the record. He said he was not encouraged to do either one or the other of these things.

The applicant said he was satisfied that he got a fair hearing of his case and was treated courteously by the referee but that he does not believe the referee's decision was correct. Mr. ——— said he has asked the Appeals Council to review his denial. He was informed that he had a right to this review and that he could also take the case to the U.S. courts.

I thanked him for his cooperation.

INTERVIEW REPORT

Applicant Denied After Hearing

I interviewed this 61-year-old applicant in the home of his stepson on December 31, 1959. Mr. ——— felt that his stepfather, who speaks broken English and who at times is difficult to understand, needed his assistance and therefore he arranged to have the interview at his house. They both welcomed the interview and answered my questions freely and as completely as possible. The applicant's stepson emphasized that from his experience as a service contact man for Veterans Administration claims for the local Veterans of Foreign Wars post, he has found that it pays to exhaust all rights of appeal until the agency gives your claim an appropriate review or gives adequate reasons for denying the claim. He stated that in his opinion his stepfather's claim did not receive an adequate review and that he was not given specific reasons for the denial.

Mr. ——— is a tall, thin man with deeply recessed eyes and a long drawn face. He coughed continually during the interview. He explained that he last worked for a coal company. In 1946, when he became incapacitated with anthrasicosis, the company laid him off and placed him on the union's health and welfare rolls. He said that he drew approximately seven checks from this source before the health and welfare fund became depleted. He said that from that time to the present, he has not worked nor had an income. He said that sometime in 1949 he applied for a job as a night watchman but was turned down when the employer found out about his disability. He mentioned that he is not eligible to apply for workmen's compensation because he was not working in 1950 when this pension plan became effective.

Mr. ——— stated that he found out about the disability program from reading the newspapers and from other workers. He contacted the State unemployment office and inquired about the location of the nearest Social Security office. He was advised to go to the local Social Security contact station. In March 1958, he went to the contact station and filed his disability application. He stated that he did not have to wait long and that the field representative at the contact station treated him courteously. He felt that the disability program and his rights under it were explained to him. He said that the field representative described to him what was meant by substantial gainful activity. The representative explained that a man such as Mr. ——— who could not continue his employment because of a physical impairment could be gainfully employed as a dishwasher. Mr. ——— said he laughed at this statement. However, the field representative gave him sufficient information on which to make a decision.

Upon Mr. ———'s decision to file, the field representative began to ask certain questions and then completed the application. Mr. ——— told the field representative that the three doctors who treated him since 1946 have since died and as a result he could not get medical evidence from these sources. The field representative advised him to get an X-ray to support his claim. He was given a medical report form which he took to Dr. ———. The doctor gave him an examination and charged him \$2 for it. He was not charged for the preparation of the form. Mr. ——— went to the hospital and had an X-ray

taken of his chest and back. The X-ray was sent to his doctor and submitted by him with the medical report. Mr. ——— did not take or mail a report form to any other doctors.

Mr. ——— stated that from the time he filed his application to the date of his hearing he had been examined by three different Social Security doctors. He could not remember the dates of these examinations or when the reports of examination were submitted as evidence. He was given a breathing test by Dr. ———, a general examination by Dr. ———, and an asthma test by Dr. ———, anthrasicosis specialist.

He said that he did not feel that he needed additional assistance in preparing his claim and did not receive such assistance from other people or organizations. He said that he was well satisfied with his treatment by the field representative.

Mr. ——— stated that the denial letter did not give a satisfactory reason for his denial. He took the letter to the district office and discussed it with a claims representative there. The representative explained the rights of appeal and encouraged Mr. ——— to reopen his claim by requesting a hearing. As a result of this advice, Mr. ——— filed a request for a hearing. He did not submit additional medical evidence for the hearing.

Mr. ——— was notified by letter to appear for a hearing before the referee on June 26, 1959. The hearing was subsequently postponed to July 7, 1959. The letter also advised him of his right to be represented at the hearing. Mr. ——— attended the hearing with his stepson, who testified on his behalf, and was represented by an attorney. Mr. ——— felt that they needed legal representation in case legal points became the issue at the hearing. The attorney has not as yet charged Mr. ——— for his services.

Mr. ——— was notified of his hearing denial in September 1959. The applicant's stepson stated that the hearing was fair but that the decision of the referee was unfavorable. He stated that although the referee treated them courteously, he felt that the decision was incorrect. He emphasized that the referee made a statement at the hearing which supports his contention that the referee's decision was incorrect. He said that the referee stated, "If the doctors cannot make a decision, how am I to make a decision;" this statement was made by the referee "off the record" and is not contained in the transcript of the hearing. The applicant's stepson believes that under these conditions the referee should have consulted other doctors or requested additional examinations before rendering his decision.

Mr. ——— explained that he knew of his right to request the Appeals Council to review his case but did not consider it. He said his lawyer had explained to him that appeals to the courts are usually costly and time consuming. Mr. ——— was apparently discouraged by the lawyer's explanation and did not want to take any action. The applicant's stepson concluded the interview by saying that he had not "closed the door on the case yet." He was not certain of his course of action but intimated that he wanted his Congressman to review the case.

I thanked them for their cooperation.

THE DISABILITY INSURANCE PROGRAM—BRIEF HISTORY AND SUMMARY

The disability insurance program of the Bureau of Old-Age and Survivors Insurance, Social Security Administration, Department of Health, Education, and Welfare was established by the Social Security Amendments of 1954, as modified by the Social Security Amendments of 1956, and 1958 (42 U.S.C. 401). These acts amended title II of the Social Security Act to provide protection to a worker and his family when the worker's earnings and working lifetime cease prematurely because of an incapacitating mental or physical impairment.

Until 1954, benefits were provided for a worker and his family only in case of the worker's old-age retirement or his death. Old-age benefit payments to a disabled worker were reduced because the disabled worker's average monthly earnings, on which his retirement benefit was based, were calculated over the interval starting from a specified date and ending with the date he became 65 or died. This interval included any period of no earnings when he had been unable to work because of serious health impairment. As a result, the monthly average of his earnings under the program became smaller the longer he was unable to work. Complete loss of eligibility sometimes resulted because he lacked the number of quarters needed for fully insured status. The individual must have earned 40 quarters of coverage or quarters of coverage equal to half the number of calendar quarters elapsing between December 31, 1950 (or since he reached age 21, if later), and the quarter in which he attained retirement age or died. If he had not earned enough quarters of coverage before he became disabled to be fully insured when he attained retirement age (unless he was able to return to work and earn the necessary quarters of coverage), he would not be able to qualify for old-age insurance benefits.

Three types of protection have been provided the covered worker under the disability insurance provisions of the Social Security Act. The first, enacted in 1954 and known as the disability freeze, is a provision similar to the waiver of premium in a private insurance plan. It protects the worker against loss of insured status or reduction in the amount of retirement or survivors benefits resulting from total disability of indefinite duration.

The effect of the freeze is that:

1. When an individual's average monthly earnings are calculated, instead of using all the months in the period from a specified starting date until the date he becomes age 65 or dies, those months representing a "period of disability" are excluded.
2. If a calendar quarter is included in a period of disability, the calendar quarter is not counted as an elapsed quarter in determining the number of quarters required for fully insured status.

The changes enacted in 1954 preserved rights to old-age and survivors benefits and the amount of such benefit. No benefit could be paid until the worker reached age 65 or died. The changes made it possible for a retired worker, already entitled to old-age insurance benefits, to file, have a period of disability established and receive increased benefits. The law defined disability in 42 U.S.C. 416(i) as inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration, or blindness. No individual can be considered to be under a disability unless he furnishes such proof of the existence thereof as may be required by the Bureau.

In 1956, the Social Security Act was amended to provide for payment of monthly disability insurance benefits for eligible disabled workers aged 50 to 65. Under the act, as amended, payments begin in the seventh month after the individual is under a disability (a 6-month waiting period). The amount of the benefit is equal to the same amount an individual would receive if he were entitled to old-age insurance benefits in the first month of his waiting period. When a disabled worker reaches age 65, there is automatic conversion to an old-age insurance benefit equal to the amount of the disability insurance benefit of the previous month. The definition of a disability for benefit payment purposes is the same as for the disability freeze, except that statutory blindness does not automatically constitute disability. Cash benefits were also provided for disabled children 18 years of age or over whose disability began before reaching 18, provided the insured parent is deceased or entitled to old-age insurance benefits.

In 1958, the Social Security Act was further amended to provide cash benefits to the following members of the families of disabled workers.

1. Children under age 18 and disabled children 18 years of age or over whose disability began before reaching 18.
2. A wife aged 62 or over, or a wife under age 62 if she has in her care a child who is entitled to benefits.
3. A dependent husband aged 65 or over.

The disability insurance program is a work-related contributory social insurance program. More than 9 out of 10 workers and self-employed people are covered under the present provisions. Benefits and administrative expenses of the program are paid out of the Federal Disability Insurance Trust Fund except that benefits for disabled children of deceased workers or individuals entitled to old-age benefits are paid from the Federal Old-Age and Survivors Insurance Trust Fund. Contributions to the funds are made by employers, employees, and self-employed people. Beginning January 1, 1960, the tax rates for the combined old-age and survivors and disability insurance programs were increased to 6 percent on the first \$4,800 of the employee's wages, such tax being shared equally by the employee and employer, and to 4½ percent on the first \$4,800 of net earnings of self-employed persons. Of the 6-percent tax rate, one-half percent is allocated to the Federal disability insurance trust fund; of the 4½-percent tax rate, three-eighths percent is allocated to the fund. The portion of the trust fund not required for

current disbursement is invested in interest-bearing U.S. Government securities.

The Social Security Amendments of 1954 direct the Secretary of Health, Education, and Welfare to enter into agreements with State agencies to make disability determinations. The Secretary has authorized the Commissioner of Social Security to make such agreements, and with policies approved by the Commissioner, the Director, Bureau of Old-Age and Survivors Insurance, is authorized to execute modifications of agreements. The law provides that the determinations of disability shall be made by the Secretary, HEW, for individuals who are outside the United States, for a State that has no agreement, or for individuals not included in a State agreement. The making of these agreements by the State agencies is voluntary. State agencies make determinations of disability for applicants, and in return Federal funds are paid to the State agencies for their expenses. The standards used for the disability determinations are developed by the Bureau of Old-Age and Survivors Insurance.

Payments of disability insurance benefits started in fiscal year 1958. Estimated amounts and number of beneficiaries and their dependents are shown below.

Fiscal year	Disability insurance	
	Beneficiaries in current pay status (end of year)	Benefits paid during year
1958.....	200,000	\$168,000,000
1959.....	361,000	339,000,000
1960 (estimated).....	493,000	520,000,000

Cash benefits to the families of disabled workers began in September, 1958. As of January 31, 1960, there were 339,273 disability insurance beneficiaries and 128,882 dependents on the rolls. It is estimated that by January 31, 1960, about 100,000 living disabled workers under age 50 have had their earnings records frozen.

Benefits payable to a disabled insured individual and his dependents range from a minimum of \$33 to a maximum of \$254 a month. This is based on (1) his average monthly earnings from covered employment and self-employment and (2) the number of persons entitled to benefits as his dependents. In January 1960 the average monthly disability payments were \$89.06 for a disabled worker, \$36.06 for the dependent spouse, and \$31.04 for the dependent child.

The Bureau of Old-Age and Survivors Insurance is one of four Bureaus within the Social Security Administration, which is a part of the Department of Health, Education, and Welfare. It is responsible for assigning an identifying account number to the individual worker, maintaining his earnings history, accepting his claim for benefits, determining its validity and the amount of benefits due, certifying the amount to the Treasury Department (which issues the benefit checks) and continuously maintaining and modifying benefit rolls as people move or have their benefits suspended, changed in amount, or terminated for various reasons.

[COMMITTEE PRINT]

ADMINISTRATION OF SOCIAL SECURITY
DISABILITY INSURANCE PROGRAM

PRELIMINARY REPORT

TO THE
COMMITTEE ON WAYS AND MEANS

SUBMITTED BY THE
SUBCOMMITTEE ON THE ADMINISTRATION
OF THE SOCIAL SECURITY LAWS



MARCH 11, 1960

NOTE.—The printing of this subcommittee report has been authorized by the Committee on Ways and Means in accordance with its rules of procedure so as to make it available. Its contents have not been substantively considered by the full committee membership, and hence it has neither been approved nor disapproved by the full committee.

Printed for the use of the Subcommittee on the Administration of the
Social Security Laws of the Committee on Ways and Means

UNITED STATES
GOVERNMENT PRINTING OFFICE
WASHINGTON : 1960

COMMITTEE ON WAYS AND MEANS

WILBUR D. MILLS, Arkansas, *Chairman*

AIME J. FORAND, Rhode Island	RICHARD M. SIMPSON, Pennsylvania ¹
CECIL R. KING, California	NOAH M. MASON, Illinois
THOMAS J. O'BRIEN, Illinois	JOHN W. BYRNES, Wisconsin
HALE BOGGS, Louisiana	HOWARD H. BAKER, Tennessee
EUGENE J. KEOGH, New York	THOMAS B. CURTIS, Missouri
BURR P. HARRISON, Virginia	VICTOR A. KNOX, Michigan
FRANK M. KARSTEN, Missouri	JAMES B. UTT, California
A. S. HERLONG, JR., Florida	JACKSON E. BETTS, Ohio
FRANK IKARD, Texas	BRUCE ALGER, Texas
THADDEUS M. MACHROWICZ, Michigan	ALBERT H. BOSCH, New York
JAMES B. FRAZIER, JR., Tennessee	JOHN A. LAFORE, JR., ² Pennsylvania
WILLIAM J. GREEN, JR., Pennsylvania	
JOHN C. WATTS, Kentucky	
LEE METCALF, Montana	

LEO H. IRWIN, *Chief Counsel*

JOHN M. MARTIN, JR., *Assistant Chief Counsel*

THOMAS A. MARTIN, *Minority Counsel*

GERARD M. BRANNON, *Professional Staff*

RAYMOND F. CONKLING, *Professional Staff*

SUBCOMMITTEE ON THE ADMINISTRATION OF THE SOCIAL SECURITY LAWS

BURR P. HARRISON, Virginia, *Chairman*

A. S. HERLONG, JR., Florida	THOMAS B. CURTIS, Missouri
WILLIAM J. GREEN, JR., Pennsylvania	JACKSON E. BETTS, Ohio
JOHN C. WATTS, Kentucky	ALBERT H. BOSCH, New York
LEE METCALF, Montana	

FREDERICK B. ARNER, *Subcommittee Counsel* ⁴

¹ Died Jan. 7, 1960.

² Appointed Jan. 18, 1960.

³ For resolutions relating to subcommittees see H. Res. 182, 206.

⁴ On loan from the Legislative Reference Service, Library of Congress.

LETTER OF TRANSMITTAL

MARCH 9 1960.

HON. WILBUR D. MILLS,
*Chairman, Committee on Ways and Means,
House of Representatives.*

DEAR MR. CHAIRMAN: In my capacity as chairman of the Subcommittee on the Administration of the Social Security Laws, I am privileged to transmit herewith the first preliminary report of the subcommittee arising out of its studies and investigation into the operation of the disability freeze and disability benefit provisions of title II of the Social Security Act, as amended.

I am pleased to state that the report was unanimously agreed to by the Subcommittee on Administration of the Social Security Laws.

The report deals with certain problem areas in the disability program, such as: the Federal-State administrative structure; case processing time; the impact of rehabilitation services; the nature of the definition of disability and the lack of detailed regulations as to its application; and the confidentiality of certain substantive criteria established by the Department of Health, Education, and Welfare which are used in the determination of disability. The subcommittee was also concerned with adequate protection of the claimant's rights when he files his claim and submits his evidence, when his claim is denied, and during the formal hearing if he appeals his denial.

I wish also to take this opportunity to express my thanks on behalf of the subcommittee to the General Accounting Office, the Department of Health, Education, and Welfare, and the Legislative Reference Service of the Library of Congress for the very helpful assistance and wholehearted cooperation of their staffs in responding to requests for statistics, data, and various information used by the subcommittee in the preparation of the report. I should particularly like to emphasize that the Department made available to the subcommittee and its staff all records which the subcommittee considered pertinent.

Sincerely yours,

BURR P. HARRISON,
*Chairman, Subcommittee on Administration of the Social Security
Laws.*

CONTENTS

	Page
Introduction.....	1
Size and complexity of the program.....	3
Problem areas: Findings of the subcommittee.....	5
Federal-State structure of disability insurance program.....	5
Agreements with State agencies.....	5
How the program works.....	6
Maintenance of Federal-State structure.....	6
Authority of the Secretary to reverse denials.....	8
Length of time involved in processing cases.....	11
Interstate variation in administration.....	12
Disability definition and standards.....	13
Operational approach.....	13
Medical standards.....	16
Nonmedical standards.....	17
Substantial gainful activity.....	20
Substantial gainful activity and sheltered workshops.....	21
Rehabilitation and the disability program.....	22
Results of the rehabilitation provision.....	22
Extension of the 12-month trial work period to all beneficiaries who seek to rehabilitate themselves.....	23
Elimination of 6-month waiting period of disability insurance beneficiaries who have had a prior period of disability.....	24
Evaluation of rehabilitation potential.....	25
Effect of the disability program on State rehabilitation agencies.....	26
Protection of the claimant's rights.....	26
Representation and assistance at the district office.....	27
Representation at the hearings.....	30
Problems in appeals procedure.....	31
Reconsideration.....	33
Hearings.....	33
Review by the appeals council.....	38
Judicial review.....	40
Location of Office of Hearings and Appeals.....	42
Purchase of medical evidence.....	43
Administrative and cost considerations of the removal of age 50 re- quirement for disability benefits.....	46

ADMINISTRATION OF SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

INTRODUCTION

This is the first report of the Subcommittee on the Administration of the Social Security Laws, which was established by the Committee on Ways and Means on March 13, 1959, for the purpose of exercising continuous watchfulness over the administration of existing social security laws and to conduct appropriate studies and investigations in this connection. This report is in the nature of a preliminary report, since the work of the subcommittee in this area, as well as in other areas, is of a continuing nature. The committee, in authorizing the establishment of the subcommittee, limited its jurisdiction to the administration of existing law.

Inasmuch as the jurisdiction of the Subcommittee on Administration of the Social Security Laws covers the whole broad area encompassed by the 15 titles of the Social Security Act, it was obviously necessary for the subcommittee to select specific problem areas, even within particular titles of the Social Security Act, for initial consideration.

The first area selected for consideration and study was the administration of the social security disability program under title II of the Social Security Act. This program, was first established by the "disability freeze" provisions of the 1954 amendments and was greatly expanded by the cash benefits provisions of the 1956 and 1958 amendments.

The disability program was selected for several reasons. It is the newest and in many respects the most difficult social insurance program, from an administrative standpoint, on the statute books today. Second, and equally important, the subcommittee was concerned with the persistent complaints as to the strict interpretation of the act, and the amount of time consumed in making a disability determination and in the appeals process.

The disability insurance program is administered by the Department of Health, Education, and Welfare, primarily by the Bureau of Old-Age and Survivors Insurance¹ of the Social Security Administration. The actual determinations of disability are made, however, by 56 State agencies under contractual arrangements using standards prescribed by the Bureau.

The subcommittee undertook this study in the most objective manner possible. The study called for exploration of a variety of problem areas, including the disability system's rather complicated medical and legal aspects, the role of rehabilitation in the program,

¹ Hereafter referred to as the Department and the Bureau, respectively.

and the effectiveness of the unique State-Federal administrative organization.

As a first step, the subcommittee staff, in cooperation with the Department of Health, Education, and Welfare, prepared a 220-page book of information, "The Disability Insurance Fact Book," published early in September, to serve as background material for the subcommittee.² This book summarizes the legislative and administrative developments in the disability program. Concurrently, arrangements were made with the Surgeon General for the services of Dr. Arthur B. Price of the Public Health Service, who prepared a comparison of the social security disability system with that of the railroad retirement system, emphasizing disability evaluation standards and their application in the respective systems. Dr. Price, who had served as the chief medical consultant to the Bureau in the early years of the implementation of the disability plan, completed his report in October.³

To obtain information on the appropriateness of the disability standards used by the Department of Health, Education, and Welfare, copies of the original 1955 and the revised 1959 standards were sent to a number of medical experts on disability evaluation, asking for their comments on the level of severity established and as to whether there had been any appreciable change in that level between 1955 and the present time.⁴

To get further data on the State-Federal operation and to elicit State agency opinions on certain crucial points of the program, two rather extensive questionnaires were sent to each of the 56 State agencies which make the determinations of disability. The responses, reflecting the opinions of the State administrators, were assembled on a State-by-State basis under each question asked so that their opinions on these various issues could be clearly shown.⁵ Simultaneously, the General Accounting Office was requested to make an independent processing time study of disability cases, selected on a random basis.

During the course of these investigations a wealth of information on all aspects of the program was obtained from the Department through letters and informal communications. Some 20 of the resulting reports are printed in the hearings under the appropriate subject headings.

Before the public hearings, the General Accounting Office submitted its own report, with recommendations to the Congress and the Department, on selected aspects of the disability program.⁶

The public hearings themselves, which took place early in November, were conducted around specific problem areas with the purpose of bringing together witnesses experienced either in the actual administration of the disability program or with special knowledge in the field under inquiry.

² "Disability Insurance Fact Book: A Summary of the Legislative and Administrative Development of the Disability Provisions in Title II of the Social Security Act," prepared by the staff of the Subcommittee on the Administration of the Social Security Laws for the use of the Committee on Ways and Means (U.S. Government Printing Office, Washington, 1959. Hereafter referred to as the "Fact Book.")

³ "Administration of the Social Security Disability Insurance Program," hearings before the Subcommittee on the Administration of the Social Security Laws of the Committee on Ways and Means, House of Representatives, 86th Cong., pp. 545-574. Hereafter referred to as "hearings."

⁴ See hearings, pp. 326-327, 358-359, and 538-545.

⁵ See hearings, pp. 125-243.

⁶ This report appears in the hearings, pp. 279-324. The explanatory testimony of the GAO representatives appears at pp. 92-97.

The problem areas thus explored were Federal-State administration, November 4; disability standards, November 5; vocational rehabilitation, November 6; appeals procedure, November 9; the purchase of consultative medical examinations, November 10; and the Department's interpretation of "substantial gainful activity," November 13. At some of these sessions the invited witnesses, who had testified in the morning, joined in a panel discussion of the same phase of the program in the afternoon. Two days, November 10 and 12, were reserved for public witnesses who requested to be heard. On December 7, the Honorable William L. Mitchell, Commissioner of Social Security, appeared to give a summarizing statement of the November hearings and to discuss certain areas with which the subcommittee had expressed concern.

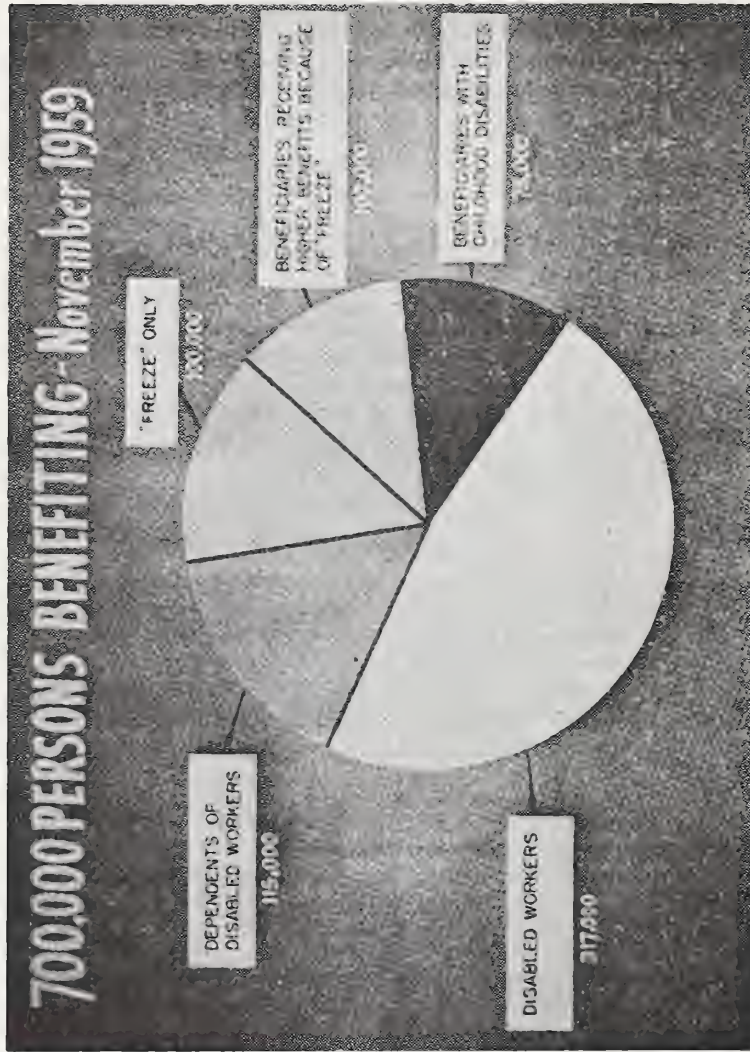
Three additional surveys were undertaken subsequent to the hearings. The first dealt with the very important but difficult problem of finding out how the disabled person who applies for benefits feels about the administration of the disability program. A random sample of these applicants—including those whose claims had been allowed, those who had been denied, and those who had appealed and received a hearing—were interviewed within a 100-mile radius of six metropolitan areas, Baltimore, Chicago, Kansas City, New York, Philadelphia, and San Francisco. At the same time, and by the same means, doctors and hospital administrators who had participated in the program were also consulted. The results of these personal interviews, which were conducted by representatives of the General Accounting Office, are reflected in this report, and the subcommittee will propose to the full committee that they be published in detail as a print of the subcommittee.

The second survey, completed in mid-February, requested comments from the 56 State agencies on the Department's proposal for legislation which would give the Secretary the power to reverse State denials of claims. (See pp. 9-11.) Another survey, also completed in mid-February, requested information from the 110 social security hearing examiners concerning their status under the Administrative Procedure Act and on certain other questions as to claimant representation.

SIZE AND COMPLEXITY OF THE PROGRAM

The subcommittee has been impressed both by the magnitude and by the complexity of the program.

Today about 750,000 disabled persons and their dependents are benefiting from the disability provisions, including both the disability freeze and the cash benefits program. Over 1.3 million substantive determinations as to disability have been made, and such determinations are continuing at a rate of approximately 30,000 a month. It is only at the present time that the Bureau of Old-Age and Survivors Insurance and the 56 contracting State agencies are emerging from a chronic backlog situation. This situation resulted largely from the fact that the disability "freeze" provisions in the 1954 amendments and the disability benefits provision in the 1956 amendments covered not only persons currently becoming disabled, but also persons whose onset of disability went as far back as 1941. The administrative



problem of working through this backlog was aggravated, moreover, by the 1958 amendments which liberalized the coverage requirements for disability benefits.

It is clear that these determinations of entitlement to cash disability benefits or to a disability "freeze" involve many more complicated considerations than does the process of determining eligibility for retirement or survivor benefits. In most case it is relatively easy to determine when a given age has been reached, when death has occurred, and to ascertain the nature of the family relationships which entitle dependents and survivors to benefits. However, each substantive determination of disability calls for an individual application of a set of necessarily complex medical and vocational facts to the definition of disability which is in the Social Security Act, the precedents and interpretive guides for which have been of an evolutionary rather than an established nature. These determinations have been made in a pioneering atmosphere without precedent in other Federal disability insurance programs and further complicated by the quantitative aspects of the workload and the unique decentralized method of disability evaluation.

PROBLEM AREAS: FINDINGS OF THE SUBCOMMITTEE

FEDERAL-STATE STRUCTURE OF DISABILITY INSURANCE PROGRAM

Agreements with State agencies

The disability insurance program is administered by the Department under a Federal-State arrangement having its origin in the disability "freeze" provisions of the 1954 amendments to title II of the Social Security Act. Congress specified that determinations of disability should be made by State agencies, under agreement with the Secretary. As anticipated, State rehabilitation agencies generally are the ones that carry out this function. The report of the Committee on Ways and Means on the 1954 amendments stated that this method of administration—

would serve the dual purpose of encouraging rehabilitation contacts by disabled persons and would offer the advantages of the medical and vocational case development undertaken routinely by the rehabilitation agencies (H. Rept. 1698 to accompany H.R. 9366, 83d Cong., 2d sess., p. 23).

This Federal-State pattern introduced an entirely new concept in the Federal social insurance system. Unlike the grant-in-aid programs, the relationship between the Department and the States is in the nature of a contractual one, with no substantive State law involved. However, State laws and practices are controlling with regard to many administrative aspects. The State agency and State employees, acting in behalf of the Secretary of Health, Education, and Welfare, make a determination of disability on the basis of standards and guides provided by the Department. The cost of the determination and other aspects of the State disability operation are paid from trust fund money by way of advancements of funds or reimbursement to the contracting agency.

Agreements are now in effect with 56 contracting agencies in 52 jurisdictions; in 4 States the Governors designated 2 contracting agencies, a separate one for the blind. The contracting agency designated by the State is a vocational rehabilitation agency, except in

four States (New York, North Carolina, Oklahoma, and Washington) where it is the agency administering the public assistance programs.

The basic agreements entered into by the States following the institution of the "freeze" program in 1954 have continued in effect without major changes. However, successive modifications of each agreement have been necessary to carry out amendments to the law and to adjust the States' jurisdiction over certain classes of cases. Except for some minor exclusions (railroad and foreign cases) the States are now accepting jurisdiction over all cases requiring a determination of disability.

How the program works

The applicant files his disability claim in the local district office of the Social Security Administration. In the course of the interview the applicant is asked to supply information on the nature and extent of his impairment, the way it limits both his daily activities and his ability to work, the medical treatment he has received, his education and work experience, and other facts pertinent to the evaluation of his disability. If it is clear that the applicant does not meet the coverage (length of service) requirements of the act he is notified that his claim has been denied on this basis. (For a complete description of development of the claim at the district office see Fact Book, pp. 45-46.)

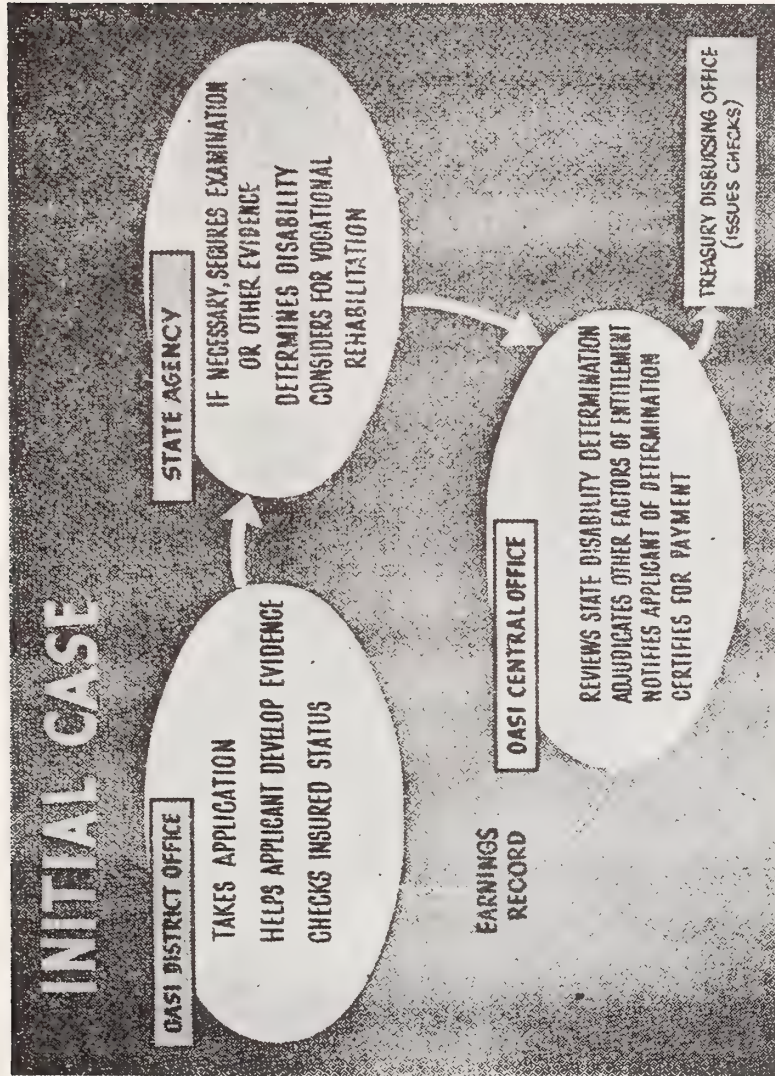
After the interviews and development of evidence, the claimant's file is sent to the appropriate State agency for determination of disability. Determinations of disability (or no disability) are made by teams of State agency physicians and disability examiners. There is some variation among the States as to the amount of participation by State agency doctors, but in all States the doctor and lay adjudicator each sign the disability determination.

The Bureau in its headquarters in Baltimore, Md., reviews all State agency determinations for consistency with the Department's standards, and communicates with, or returns a decision to the agency when it questions the determination. The Bureau notifies the applicant of the decision in his case and, if the decision is adverse, informs him of his right to reconsideration and appeal. Where an award of disability benefits is in order, it certifies the payment to the Department of the Treasury.

The subcommittee has gathered extensive information covering the administration of the Federal-State system from administrators at the Federal and State level, vocational rehabilitation specialists, the medical profession, representatives of organized labor, and from the General Accounting Office. The following are the major areas in which significant issues were raised.

Maintenance of Federal-State structure

The subcommittee heard testimony to the effect that the basic justification for the Federal-State structure—to give emphasis to the vocational rehabilitation program by strengthening the referral and rehabilitation process and to make use of established relationships with medical and other professional groups—is still sound. (The rehabilitation aspects are discussed in the section on "Rehabilitation and the Disability Program," pp. 22-26.)



The subcommittee is impressed with the effective relationships which have been and are being maintained with the medical profession at the local and national level. This is due, in large part, to the tactful and understanding leadership of the Bureau's Division of Disability Operations and to the work of the Social Security Administration's Medical Advisory Committee. These effective relationships would not have been possible, of course, without the cooperative attitude of the medical profession and the American Medical Association.

The medical experts on disability who testified before the subcommittee all agreed that the State agencies should make the determinations of disability.⁷ This view was also supported by the American Medical Association which urged that the decentralized administration of the disability insurance program be continued since differences in local customs and conditions require negotiations and arrangements on a State-by-State basis.

The subcommittee also heard adverse testimony bearing on the basic Federal-State system of administration. Representatives of the General Accounting Office and of the AFL-CIO and the National Federation of the Blind raised the question of whether the Federal-State arrangement should be modified. The General Accounting Office witnesses observed that the development of the disability claim and the subsequent disability determination are so closely related that the present procedures result in some duplication of work between the Social Security Administration district offices and the State agencies. This situation, they believe, has the inevitable effect of increasing processing time and cost. A representative of the AFL-CIO stated that it seemed more important that the offices making determinations be part of the same agency which has the overall responsibility for administering the disability program, than for these offices to be part of the agency which is responsible for rehabilitation (hearings, p. 841).

The Commissioner of Social Security, William L. Mitchell, testified that the basic Federal-State structure should be maintained at least for the present, although he believes that, from a social insurance point of view, a direct-line Federal operation could be expected to result in simpler and more efficient procedures, with possible improvements in uniformity and processing time. He pointed out that a substantial commitment has been made to State agencies administering the disability program and that it could be seriously disturbing to State rehabilitation programs to withdraw from this arrangement at this time.

Authority of the Secretary to reverse denials

A denial of disability benefits by the State agency cannot be reversed by the Secretary of Health, Education, and Welfare or be made more lenient as to the onset date, except on appeal by the claimant. The law does, however, give the Secretary the authority to reverse allowed claims. Under the present administrative practices,

⁷ This group included: Dr. George F. Gsell, of the AMA's Committee on the Rating of Physical Impairment; Dr. William A. Sawyer, medical consultant to the Machinist's Union; Dr. Leo Price, medical director of the Union Health Center in New York City; Dr. Charles L. Farrell and Dr. J. Duffy Hancock. It should be noted that Dr. Hancock is chairman of the Medical Advisory Committee to the Social Security Administration and Dr. Price and Dr. Farrell are members of this committee.

the Bureau returns both allowances and denials which it questions to the State agencies, with comments on the nature of the disagreement. In most cases, the differences are resolved and there is a meeting of the minds after one return to the State agency. Sometimes, however, one or more "Bureau bounces" may occur (Fact Book, pp. 110-116).

The Commissioner of Social Security testified that in only a few cases, at most no more than 40 a month, does the State agency refuse, ultimately, to change a denial with which the Bureau disagrees. Likewise, it appears that a substantial number of these 40 cases are, upon appeal by the claimant, allowed by a hearing examiner who hears the case, in on-the-record proceedings.

The Department has expressed to the subcommittee its serious concern with the fact that it does not have the authority, where it is convinced that a denial should be an award, to change such a State agency decision. Its spokesmen have stated that the denied applicant does not always exercise his right to contest and, under these circumstances, a decision which the Bureau believes to be erroneous would stand. This situation, they believe, restricts the Secretary in discharging his responsibility of assuring uniformity in decisions of State agencies. The Department further points out that, if the denial is contested, and ultimately reversed after a hearing, the benefits to which the applicant is entitled are delayed. Delay would also be avoided, they state, in about 600 cases a month where the Department would reverse denials almost all of which the States, under the present arrangement, would have eventually agreed to change.

The representatives of the AFL-CIO and American Public Welfare Association were in favor of the Department's proposal to give the Secretary the authority to reverse State denials, but there was little testimony by the State agencies or the representatives of the medical profession on the proposal at the hearings. After receiving a letter of amplification of the proposal from Social Security Commissioner Mitchell on January 13, 1960, the subcommittee wrote a letter to each State agency head, requesting their comments on this proposal. At the same time State agency views were also requested on two alternative proposals suggested at the hearings, under one of which the Bureau would inform the claimant of its disagreement with the State agency and allow the claimant to appeal the disputed decision to a hearing examiner. Under the other suggested variation, the Bureau itself would be allowed to appeal the decision to a hearing examiner.

Returns from 46 of the State agencies, show that 27 believe that the present system should be retained, 16 are favorable (or favorable with qualifications) to the Department's proposal, and 3 are neutral. No comments were received from the balance of the States. There was little support for the proposal to inform the claimant of the disagreement and allow him to appeal to a hearing examiner, and only slightly more for the alternative which would allow the Bureau to appeal the decision to a hearing examiner. The following is a table which shows the result of the survey.

*Summary of State agency reactions¹ to Administration proposal, to alternative plan
and to variations*

State	Administration proposal	Alternative	Variation on alternative
Alabama			
Alaska	Favorable	Unfavorable	Unfavorable.
Arizona	do.	No comment	No comment.
Arkansas			
California	Favorable	No comment	Do.
Colorado	do.	Favorable	Favorable.
Connecticut	Unfavorable	Unfavorable	Unfavorable.
Delaware:			
VR	Qualifiedly favorable	No comment	No comment.
Blind	Favorable	Unfavorable	Do.
District of Columbia	Unfavorable	do.	Favorable.
Florida	do.	do.	Unfavorable.
Georgia	do.	do.	Do.
Hawaii			
Idaho	Unfavorable	Unfavorable	Do.
Illinois	do.	do.	Favorable.
Indiana	Qualifiedly favorable	No comment	No comment.
Iowa	Unfavorable	Unfavorable	Unfavorable.
Kansas	Neutral	No comment	Favorable.
Kentucky			
Louisiana			
Maine	Favorable	No comment	No comment.
Maryland			
Massachusetts	Unfavorable	Unfavorable	Has merit.
Michigan	Favorable	do.	No comment.
Minnesota	Unfavorable	No comment	Favorable.
Mississippi	do.	Unfavorable	Unfavorable.
Missouri	do.	do.	Do.
Montana	Favorable	do.	No comment.
Nebraska	do.	do.	Do.
Nevada	Qualifiedly favorable	No comment	Do.
New Hampshire	Unfavorable	Unfavorable	Do.
New Jersey	do.	No comment	Do.
New Mexico	do.	Unfavorable	Unfavorable.
New York	do.	do.	Do.
North Carolina	Favorable	do.	No comment.
North Dakota	Unfavorable	do.	Unfavorable.
Ohio	do.	do.	Favorable.
Oklahoma	Favorable	do.	Unfavorable.
Oregon	Unfavorable	do.	Qualifiedly favorable.
Pennsylvania:			
VR			
Blind	Unfavorable	No comment	No comment.
Rhode Island	do.	Unfavorable	Favorable.
South Carolina:			
VR	do.	do.	Unfavorable.
Blind			
South Dakota	Unfavorable	No comment	No comment.
Tennessee	do.	Unfavorable	Unfavorable.
Texas			
Utah	Unfavorable	Unfavorable	Favorable.
Vermont	Favorable	do.	No comment.
Virginia	Neutral	do.	Do.
Washington	Qualifiedly favorable	do.	Do.
West Virginia	Unfavorable	No comment	Do.
Wisconsin:			
VR	Neutral	Acceptable	Acceptable.
Blind	Unacceptable	No comment	No comment.
Wyoming	Unfavorable	Unfavorable	Unfavorable
Puerto Rico			

The States defending the status quo argued that the number of questioned reversals which would ultimately be changed was not great enough to merit such a basic change in present Federal-State relationships, even assuming that they were wrong. Many of these States questioned the assumption that the State agencies were in error since they believe that the local agency is in the best position to make the ultimate decision in these borderline cases after it has seen the Bureau's comments on the returned file. These States also pointed out that Commissioner Mitchell's proposal, which would authorize 600 determinations a month at the Federal level, raises a basic question as to the function of the State agencies under the program.

Most of the State agencies which are opposed to the Commissioner's proposal also do not like the alternative of informing the applicant of the disagreement and inviting appeal. They state that such a procedure would result in loss of public confidence in the Bureau, State agencies, and the disability guides. A few States believe a system of having the Bureau itself take an appeal to a hearing examiner would be acceptable but others are of the opinion that a prejudiced hearing would result under these circumstances. A number of States noted that the Bureau is following practically this same procedure by having the applicant sign a request for a hearing and by having a hearings examiner review and act upon the file in its Baltimore headquarters without a personal appearance by the applicant.

The States which favored giving the Secretary the authority to reverse State denials gave the same reasons as those enumerated by the Commissioner, but emphasis was on the saving of time and money rather than on the point that additional allowances would result.

The subcommittee also asked the opinion of the American Medical Association on the proposals. Dr. F. J. L. Blasingame, executive vice president of the association, answered the subcommittee in the following manner:

In general, it should be stated, however, that our association would not be favorably inclined toward any amendment to the law which would remove the authority for making medical decisions from the local level. To the extent that the proposal contained in Mr. Mitchell's letter would centralize authority to arrive at medical decisions in a Federal agency, the American Medical Association would find itself in disagreement.

You do indicate in your letter, as a possible alternative, a mechanism which would permit the Bureau to appeal a case directly to a referee in a situation in which it was in disagreement with a State agency disability determination. Again, although we do not have a firm policy in this regard, it would appear that the alternative suggested represents a preferable procedure.

In closing, I should like to point out again that the American Medical Association does not consider itself expert in questions involving administration of this program; and, therefore, the above represents general observations rather than firm association policy.

Length of time involved in processing cases

Concern about the length of time required for processing disability claims was expressed by a number of witnesses before the subcommittee, including representatives of the AFL-CIO and the General Accounting Office.

Spokesmen for the Department testified that the Bureau is also concerned with the length of time required for disability processing but pointed to improvements which had been achieved in this area, especially now that the backlog of cases has largely been cleared up. For example, in December 1957, the median time for processing an initial case, where the evidence did not require development by the State agency, was 188 days. The 188 days median time was distributed as follows: 68 days in the district office, 55 days in the State agency, 45 days in central office operations, and 20 days in transit. By December 1959, the median time for this type of case had been reduced to 73 days—28 days in the district office, 12 days in the State agency, 20 days in central office operations, and 13 days in transit. The Department has advised that for 1960, a target of 66 days has been established, based on 31 days in the district offices, 10 days in the State agency, 15 days in the central office, and 10 days in transit.

For cases where it is necessary for the State to obtain additional evidence, the median time has been reduced from about 234 days in December 1957, to 119 days in December 1959, with corresponding reductions in State agency, central office, and transit time. For 1960, the Department advises that its goal for these cases is a median time of 117 days.

It appears to the subcommittee that the processing time for the reconsidered case seems unnecessarily long. For instance, in October 1959, it took approximately the same time to process a reconsidered claim as it did to process the initial determination. Considering all the documentation and evaluation which has gone into the initial determination, this result is quite surprising.

The subcommittee recognizes that the problems inherent in developing evidence of the nature and extent of each applicant's disability, and of evaluating the effect of his impairment upon his ability to engage in substantial gainful activity, make the process of determining disability more time consuming than the handling of the regular old-age and survivors insurance claims. We are pleased that the Department, with the cooperation of the States, has been able to make measurable reductions in elapsed processing times. We feel, however, that further reductions are necessary.

The subcommittee recommends that the Department continue to review its operating and processing procedures to assure that needed refinements are made to speed up case processing. In addition, the Department should continue to review and analyze the management of State operations in close cooperation with the States to achieve further refinements in operating methods so as to further reduce processing time.

Interstate variation in administration

The subcommittee received information as to substantial interstate variations in certain important areas of the disability program. These areas were: (1) denial rates; (2) State cases questioned by the Bureau; (3) rate of purchase of medical evidence; (4) processing time; and (5) case costs and operating methods and procedures.

Concern about the extent of these variations was expressed by departmental representatives and in the report of the Comptroller General on the disability insurance program. *The subcommittee believes that wide interstate variations are inconsistent with the Department's purpose of providing objective, uniform, and equal treatment of disability applicants.*

State agency denial rates, for instance, ranged from 27.4 to 56.5 percent for the first 6 months of 1959. The increasing number of cases referred back to the States for further consideration of their decision reflects the Department's attempt to achieve greater consistency. The range between States in the percentage of questioned cases returned gives some indication of the depth of this problem: 0.7 to 19.2 percent for April-June 1959.

The Department testified that some variations in denial rates exist because demographic characteristics such as age, sex, employment factors, type of impairment, and others related to the incidence of disability, differ significantly among the States. Likewise, there is some evidence that the Department's efforts to reduce the variation in denial rates between the States are achieving results. The sub-

committee observes, however, that there are still significant variations in interstate denial rates which warrant further examination.

Preliminary data on the characteristics of the cases in which medical evidence is purchased suggest that there is probably a relationship between variations in rates of purchase and such factors as age, date of onset of disability, whether the applicant was institutionalized, the type of impairment, and the level of medical practice available in various communities. There is also evidence that some States have not fully accepted Bureau criteria in this area and that these criteria could be made more explicit. The Department has testified that the range in variation is narrowing.

The subcommittee heard testimony from departmental spokesmen and the Comptroller General as to the extent of the variations in cost per determination among the States. Leaving out five small agencies with minimal workloads, the average total cost per case State-by-State ranged from a low of \$14.31 to a high of \$32.07. We note, however, that three-fourths of all agencies are concentrated within the range of \$18 to \$30. While some of the variations in costs between States admittedly are beyond the control of the individual agencies, e.g., differences in State compensation plans, scheduled working hours per week, and fees for medical examinations, we believe that better operating procedures should reduce at least some of the cost variations.

Particular emphasis is needed in pushing forward, in the adjudication process, the effective communication to the State agencies of the nature of the disability guides and their method of application. There was considerable evidence that the questioning and returning of substantial numbers of decisions to the States could have been avoided if, prior to such a return, there had been more of a meeting of the minds between the Bureau and the State agencies as to the disability guides. Many of the State agencies suggested the need for better liaison with the Bureau and suggested training sessions and more visits from Federal personnel skilled in the use of the standards. Other agencies also pointed to the desirability of having one person skilled in disability matters in each regional office—the Bureau's liaison office with which the State agency usually deals.

DISABILITY DEFINITION AND STANDARDS

Operational approach

The subcommittee has examined the charges which have been made that the Department's interpretation of what constitutes disability has been more strict than is warranted by the law and the legislative history of the 1954 and 1956 amendments. The definition of disability does, however, require—

inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long continued and indefinite duration (secs. 216(i), 223(c)(2)).

This broad language and the legislative reports supply few guidelines for interpretation, but the Congress has stated clearly that an occupational definition was not intended. This fact is still not understood by many people who confuse the definition with definitions in other programs.

Within the last year there have been some indications of what might be termed a slight liberalization in the application of the definition through the mechanism of more complete documentation and consideration of disability cases. Although the Department maintains that this does not constitute any change in the disability standards or their application, it seems clear that more borderline disability cases are being allowed today than was the case 1 or 2 years ago. Also, the repeal in 1958 of the requirement that an individual must have worked for $1\frac{1}{2}$ of the 3 years just before the disability was incurred has had the effect of granting benefits in more cases. Under present law, an individual with a progressively worsening condition that may become totally disabling at a later point, can retain his insured status for as long as 5 years after he stops working.

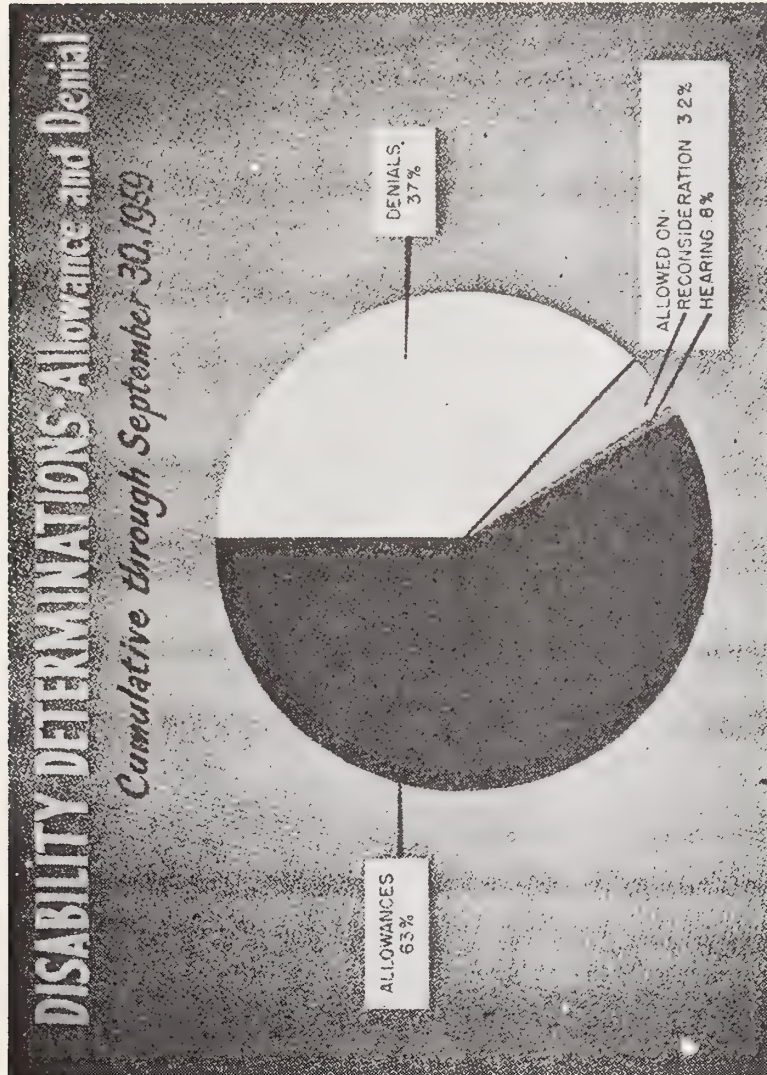
Perhaps the greatest problem at the present time is not so much the question of the "strictness" of the interpretation of the definition, but the more basic question of whether adequate regulations have been promulgated to provide guidelines necessary for a consistent and uniform understanding of what constitutes disability under the act.

It should be noted that the Social Security Board (now the Social Security Administration), when it implemented the appeals and hearing process provisions of the law in 1940, stated:

In order to minimize the number and seriousness of the doubtful questions requiring determination in particular cases as they arise, it is desirable to have these substantive regulations as detailed and as capable of direct application to specific factual situations as possible. ("Basic Provisions Adopted by the Social Security Board for the Hearing and Review of Old-Age and Survivors Insurance Claims * * *," reprinted as appendix to Monograph No. 3 of the Attorney General's Committee on Administrative Procedure, S. Doc. 10, 77th Cong., 1941, at p. 53.)

It is highly questionable whether the present regulations adequately inform claimants of their rights, or give Congress the information necessary to exercise its legislative functions. Moreover, it appears that, in the absence of detailed regulations, the Federal judiciary is filling the void with a variety of interpretations, some of which might eventually affect the actuarial soundness of the system.

The general procedure apparently being followed is the pragmatic approach advocated by the Advisory Council on Social Security to the Senate Committee on Finance (1949)—a legislative definition written in rather broad terms to be implemented by more specific administrative regulations on the basis of operational experience. The development of operational "case law" has been going on for some time, but very little of it, thus far, has been made public in the form of regulations.



Medical standards

The subcommittee has been impressed with the medical evaluation guides worked out by the Bureau in consultation with the Social Security Administration's Medical Advisory Committee. These guides describe the most common impairments which are severe enough to prevent "most" people from working. An impairment meeting the level of the guides is considered presumptively disabling on the medical facts alone in the absence of work activity. Understandably, the guides do not show all possible disabling conditions, nor do they indicate the combined effects of several impairments. But they do spell out the symptoms that usually exist in some specific impairments, the resultant organic changes, and the laboratory findings that usually indicate such impairment.

The efficacy of these guides was attested to by all the medical experts on disability who appeared before or submitted statements to the subcommittee. Dr. George Gsell of the American Medical Association's Committee on Medical Rating of Physical Impairment summarized this opinion when he described the guides as "very adequate" and "appropriate" and declared that the Bureau and the Medical Advisory Committee were "to be commended for a job well done" (hearings, p. 358).

Some of the guides have been amended since they were first instituted in 1955. Testimony before the subcommittee indicates that these developments have not effected a basic change in the level of severity for presumptive allowances. Rather, they have been of a clarifying nature or are a reflection of further progress in disability evaluation technique. *The subcommittee believes that the medical standards should continue to be developed in this evolutionary manner so that the results of research in modern medicine and the fast-changing science of disability evaluation are fully utilized.* The Bureau, itself, is to be commended for instituting research looking toward more meaningful methods of disability evaluation.

The subcommittee notes, however, that the medical evaluation standards are limited to the internal use of personnel of the Department and the State agencies. The justification put forth by the Bureau and the Medical Advisory Committee is that their publication would be undesirable inasmuch as they are only "guides" and do not fully communicate the bases for decisions. Moreover, as noted, their primary function is to provide a mechanism for presumptive allowance of a large volume of clear-cut cases. Spokesmen for the Bureau also stated that it would not be wise for examining physicians throughout the country to have information available on exactly what it takes to qualify under the program (hearings, p. 29).

On the other hand, representatives of the legal profession find it objectionable that criteria which, to some degree, determine eligibility for disability benefits are not available to the individual prosecuting his claim (hearings, p. 877). They hold that the fairness of the proceeding is not enhanced by the fact that these guides are available to the Federal and State evaluators and to the hearing examiners.

The subcommittee also notes that the regulations which have been published on the medical standards are extremely general and would seem to be useful in only the most obvious cases. The most comprehensive statement on the medical standards is contained in OASI pamphlet 29f, "Disability and Social Security." This publication,

however, does not carry the weight of formally promulgated regulations. *Spokesmen from the Bureau stated at the hearings that the Department intends to expand the regulations in regard to the medical standards. The subcommittee urges that this be done at the earliest opportunity and that the medical guides which are essential to the individual in prosecuting his case should be made public. The subcommittee realizes that it may be justifiable, as Commissioner Mitchell stated in the hearings, that "certain of the administrative devices used or certain of the types of investigation that are made" should not be disclosed (hearings, p. 970), but it believes that it is very important that the claimant be informed of the substantive standards which are applicable to these determinations. It is essential that the convenience of confidentiality not be extended to the basic rules of game.*

Nonmedical standards

Even though a claimant's impairment does not reach the presumptive level of medical severity, he is not necessarily disqualified from benefits because nonmedical standards must also be used in the evaluation process. In such a situation the disability evaluator considers the combined effect of all the applicant's conditions, including his age, education, training, and work experience. The Department testified that in 70 percent of the disability insurance benefit allowances the applicants are meeting squarely the factors specifically listed in the medical guides; that 20 percent are being allowed because of unlisted or combined impairments equivalent in severity to those in the guides; and that 10 percent are being allowed with special weight being given to the nonmedical factors where the impairment did not reach the presumptive medical level. For the period from January 1958, through September 1959, allowances because of nonmedical factors increased from 7.6 percent to 10 percent in benefit cases.

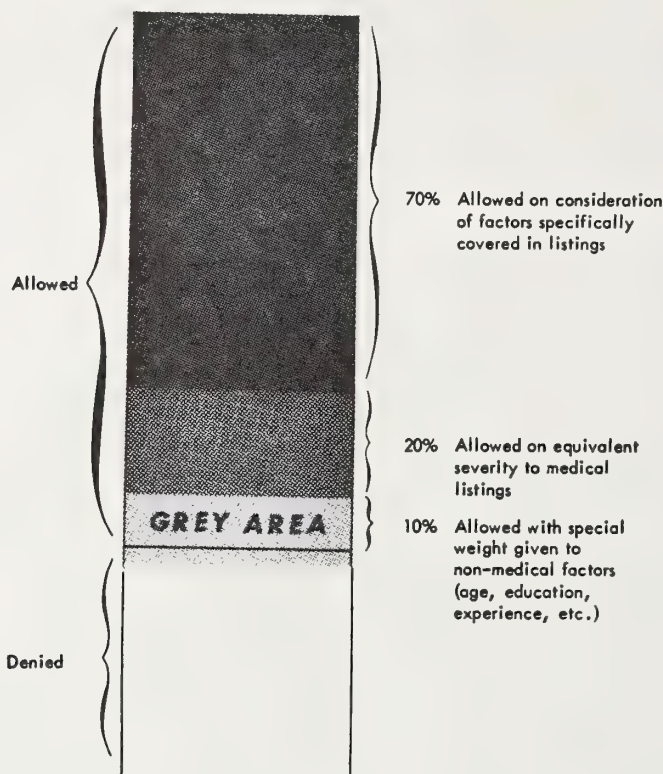
As was the case with the medical standards the published regulations are skimpy in regard to the nonmedical standards, stating merely that "consideration is also given to such other factors as the individual's education, training, and work experience." Age, for instance, is not even mentioned in the regulations, although it is a factor included in the confidential manual. The guides in the confidential manual are a little more explicit but, unlike the guides provided for the medical standards, they have not been clarified or enlarged since 1955. In an informal interagency statement, a Bureau official said as early as March 1957:

We are trying to formulate guides that will be more helpful to evaluation teams in describing more precisely the nonmedical factors, e.g., the social and vocational facts in the applicant's situation that influence his reaction to his impairment and his ability to do and hold a job. Possibly we may also be able to be more specific about the relative weight that may be accorded the social and vocational factors in the disability evaluation. * * *

All of us know that in evaluating disability such nonmedical factors as age, education, vocational skills, work experience, etc. must play a part in deciding whether a given individual with a severe mental or physical impairment can or cannot engage in substantial gainful activity. We will continue in our efforts to develop criteria and guides in this area, but meanwhile each of us in the adjudication of disability must give consideration to such factors even though we have nothing more than our "commonsense" to guide us (hearings, p. 87).

EVALUATION GUIDES

Use of medical listings and non-medical factors
Initial Disability Insurance Claims (age 50-65)



This statement is equally applicable today and certainly the need for such guides is no less compelling. *The subcommittee recognizes the difficulty of developing and enunciating specific criteria for the weight to be given nonmedical factors in the evaluation of disability and the extreme sensitivity of this area. But the subcommittee believes that the time has come, if it is not well overdue, to make a determined effort to develop and refine these criteria and make them available to the evaluators and to the public in the form of published regulations.*

The subcommittee recognizes, moreover, the need for the realism in disability determinations which the skillful use of nonmedical factors can bring. Witnesses for the Bureau testified that, through review and return of individual State agency case decisions, they believe they have been moving constantly toward the more effective consideration of nonmedical factors. The great majority of the State agencies, in answer to a subcommittee questionnaire, stated that they had noted and approved of a recent tendency of the Bureau to put more emphasis on nonmedical factors such as age (hearings pp. 201-207).

The subcommittee believes that this is a sound approach, but again suggests the need for more explicit guidelines. The subcommittee also gives great weight to the testimony of the medical experts on disability who believe that the emphasis under the program should remain on the medical impairment. As Dr. Leo Price, medical director of the Union Health Center in New York, cautioned. "If you have too much latitude in the exercise of nonmedical standards, the cost might rise to a very high point" (hearings, p. 507).

Ability to do a job versus ability to get a job.—The subcommittee takes note of the very real problem of employability in a disability program. Lack of ability to engage in a job is essential to a determination of disability under the social security disability insurance law as it is currently being interpreted. Lack of ability to get a job, however, is immaterial, or at least so in theory, under the law and the Bureau's practices. In interpreting the words of the law which state that any individual must "be unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment" the Bureau has held that there must be both lack of capacity to do a job and that the individual's impairment must be the primary cause of this lack of capacity. The regulations are not any more specific in this area but an OASI pamphlet (OASI-29f) has stated that:

A person may become unemployed or remain unemployed for a number of reasons other than disability: individual employer hiring practices, technological changes in the industry in which the applicant has been employed, local or cyclical business or economic conditions, and many others. The disability provisions are intended to benefit only those persons who are not working because of incapacity, and not those unemployed because of these other factors.

The subcommittee recognizes that this distinction is difficult for the public to understand, particularly for those individuals who have been denied disability benefits, but who are not good prospects for employment in view of employer practices and the condition of the local labor market coupled with their impairment.

Those persons, of undetermined number, who have been denied disability benefits but still cannot qualify for vocational rehabilitation services because the State agency has determined that such services would not "reasonably be expected to render him fit to engage in a remunerative occupation," find it even more difficult to understand this distinction.

Lack of public understanding occurs most often in the case of older workers approaching retirement age who may be unable to find new work following a period of acute temporary illness or who may be out of work because of the general employment problems of older workers. Criticism is also encountered in depressed areas or in a one-industry town, particularly if the older worker can no longer meet the special medical conditions associated with employment in the industry.

Under a program that affords protection only against incapacity for any substantial gainful activity, there is a problem with respect to the individual who may have been slowed down somewhat by advancing age and a chronic condition which, in the light of job hiring standards, may affect his ability to find a job, but which is not a major handicap to carrying on the actual work if found. The claimant survey showed that only 16 of 97 denied applicants stated that they were engaged in work activity.

The subcommittee believes it is essential that there be a clear distinction between this program and one concerned with unemployment. It also believes it is desirable that disability determinations be carried out in as realistic a manner as possible, and that theoretical capacity in a severely impaired individual can be somewhat meaningless if it cannot be translated into an ability to compete in the open labor market. *The subcommittee believes that the Department should make a thorough study of this situation to see if criteria can be developed which retain the basic emphasis of the program on major medical impairment but at the same time allow for a more realistic assessment where there are multiple bars to employment, e.g., age, employer bias in hiring, and other factors that limit job opportunity.*

Many answers to the subcommittee questionnaire to State agencies noted this as a problem area (hearings, pp. 201-205). The answers also indicated the possibility that different approaches are being used by various State agencies. Here, again, the evidence shows that there is need to elaborate both the regulations and the evaluation guides which govern the disability determination terms.

Substantial gainful activity

This crucial term in the definition of disability is not itself defined in the law or explained in the appropriate legislative reports. Again it may be noteworthy that the Advisory Council on Social Security to the Senate Finance Committee (1949) stated:

The exact limits of what constitutes "substantially gainful activity" should, in the early years of the program, at least, be defined by regulations. After the program has been in operation, administrative experience will doubtless indicate ways in which the definition can be improved. Leaving the definition to regulations will make it possible to take prompt advantage of that experience. The Council believes, however, that the regulations governing this definition should be strict (S. Doc. 208, 80th Cong., 2d sess., p. 73).

It has been almost 6 years since the concept of "substantial gainful activity" was enacted into law for the disability "freeze" and it has been used almost 4 years for the cash benefits program. During this time, however, this phrase has not been defined in the regulations, and the criteria that State and Federal agency evaluators have used are contained in the confidential manual. This, in particular, is an area where the Federal courts are without guidance and as a result have ruled in a variety of ways. The distinct possibility exists that if the situation remains unchanged the courts rather than the Department or Congress will set the standards.

Illustrative of the need for clarification is the following: The regulations now state merely that the claimant's medically determinable impairment must be of such severity that considering his "education, training, and work experience" he is unable to engage in "any substantial gainful activity." Some Federal judges, however, have concluded that these factors are relevant not only in determining capacity to engage in such activity but are also relevant in determining what type of activity would be "substantial gainful activity" for the particular individual. They have declared, in effect, that "substantial gainful activity" will be different for various individuals and that it cannot be equated with the concept of being unable to perform any

gainful work. For instance, Judge Kaufman of the southern district of New York has declared:

Even assuming that plaintiff was physically capable of engaging in clerical work it does not necessarily follow that he was able "to engage in any substantial gainful activity." Implicit in this criterion is that the gainful work be commensurate with the plaintiff's educational attainments, his training and experience (*Jacobson v. Folsom*, 158 F. Supp. 281 (S.D.N.Y., 1957), see also *Teeter v. Flemming*, 270 F. 2d 871 (C.A. 7, 1959)).

These statements are at variance with the administrative policy of the Department and the decisions of other district and circuit courts.

The Committee on Ways and Means stated in its report on the 1956 legislation that it had—

designed a conservative program of disability insurance benefits (H. Rept. 1189, to accompany H.R. 7225, 84th Cong., 1st sess., p. 5).

The report on the 1954 legislation declared that the standards should reflect—

the requirement that the individual be disabled for not only for his usual work but also for any type of substantial gainful activity (H. Rept. 1698, to accompany H.R. 9336, 83d Cong., 2d sess., p. 23).

The subcommittee believes that in order to assure uniform interpretation by the courts, as well as to afford an opportunity for effective congressional appraisal of the overall program, the present interpretation of the Department should be spelled out by regulation at the earliest opportunity.

Present Department policy in interpreting the effect of earnings on a finding of "substantial gainful activity" is found in the confidential manual, which states that if an individual earns over \$1,200 a year he is engaging in "substantial gainful activity" in "absence of evidence to the contrary." The binding nature of this guide is shown by the fact that, upon subcommittee request, a survey was undertaken which showed that no disability beneficiary was maintained on the rolls after he demonstrated an earning capacity of more than \$1,200 a year in competitive nonsubsidized employment.

Whatever may be the merits of establishing uniform dollar guides for evaluating the substantiality of actual work activity, we believe such guides are of a substantive nature, and should be made available to the claimants and to the courts. The subcommittee notes that the Department, during the hearings, has agreed to promulgate more detailed regulations on "substantial gainful activity" which will include the earnings guides. We are aware that some apprehension has been expressed that the publication of these guides could lead to voluntary limitation of earnings on the part of individuals to avoid termination of benefits, but the subcommittee is confident that the Bureau will be able to work out administrative techniques which will assure disability benefits only to those who are truly incapable of engaging in "substantial gainful activity."

Substantial gainful activity and sheltered workshops

The same earnings guides that apply to work in general are applicable to work in sheltered workshops. In applying these earnings guides, only actual earnings, as distinguished from subsidies, are considered.

A representative of the National Federation of the Blind requested that the subcommittee study the question of whether—

employment in a sheltered workshop which is heavily subsidized by charitable contributions, on "busy" work at substandard wages, is substantial gainful activity (hearings, p. 910).

The Department has advised the subcommittee that its research and case experience shows that employment in sheltered workshops may range from submarginal work to fully productive work comparable to the requirements of jobs in the competitive labor market and that employee earnings are, in some instances, quite considerable.

The subcommittee is not convinced at this time that it would be desirable to assume that work in a sheltered workshop per se indicates inability to engage in "substantial gainful activity." The Department maintains that the nature of such employment varies greatly and blanket exception would infringe on the policy of deciding each disability case on its own individual merits. The subcommittee believes, however, that the criteria which govern the terms "sheltered work," "made work," or "subsidies" should be put into published regulations at the earliest possible time. This is another illustration of an area where the basic substantive guides are contained in the confidential manual and are not available to the claimant.

Although the subcommittee does not recommend a blanket exception for sheltered workshop employees, it is sympathetic to the problems which many of these employees encounter in rehabilitating themselves. Many of these people are unable to develop the skill and efficiency needed to earn more than negligible amounts or to qualify for employment outside the sheltered workshop. It should be a rare case in which a severely impaired individual who can market his skills only in a sheltered workshop and is capable of productivity resulting in very low earnings would be found able to engage in "substantial gainful activity."

REHABILITATION AND THE DISABILITY PROGRAM

The first operative disability provisions in title II of the Social Security Act were enacted by Congress in 1954, in a rehabilitation setting. In its report on these amendments, the Committee on Ways and Means said:

The bill is framed to carry out your committee's objective that disabled individuals applying for disability determinations be promptly referred to State vocational rehabilitation agencies, to the end that as many disabled individuals as possible may be restored to gainful work (H. Rept. 1698, 83d Cong., 2d sess., p. 22).

Results of the rehabilitation provision

The subcommittee is impressed by the great magnitude of the referral program, but is somewhat disappointed by the relatively small number of the people actually rehabilitated. We heard reassuring testimony from the Office of Vocational Rehabilitation, the representatives of the State agencies, and other rehabilitation experts to the effect that it was too early to judge the results of the rehabilitation provisions on the disability program.

The Office of Vocational Rehabilitation submitted statistics, based on reports from State agencies, which showed that, by the end of September 1959, a total of 1,417,000 disabled persons (applicants and nonapplicants) have been referred to State vocational rehabilitation agencies by social security district offices. *About 4,000 of these were reported as having been rehabilitated by the end of June 1959.*

The Bureau of Old-Age and Survivors Insurance, which collects reports on referrals on a case-by-case basis, stated that by the end of June 1959 about 35,000 applicant-referrals had been accepted for rehabilitation services. Of this number 24,000 were receiving or awaiting services; 7,900 cases were closed as not rehabilitated; and 900 beneficiaries and 2,200 denied applicants had been rehabilitated.

The subcommittee became concerned, during the course of its study and its hearings, with the lack of uniform and comprehensive statistics in the rehabilitation area. The Bureau of Old-Age and Survivors Insurance collects them for one purpose, and the Office of Vocational Rehabilitation for another. These statistics are derived from different sources and at different times. Moreover, there seems to be considerable confusion in the definition of terms used in reporting rehabilitation information, as demonstrated by the State agencies' answers to the subcommittee questionnaire.

The subcommittee, therefore, recommends that the Secretary of Health, Education, and Welfare explore means of deriving more meaningful and more uniform data covering this aspect of the program so that the Congress and the American people can be given a better picture of the impact of rehabilitation on the disability program.

The subcommittee is aware, however, that statistics alone do not tell the complete rehabilitation story. Rehabilitation is a very individualized process which cannot be measured in terms of bulk alone. We recognize, too, that in the early stages of the disability program, many referrals have been aged or chronically ill people, some of whom were severely disabled as far back as 1941. Some of them were suffering from terminal illnesses, and some had been institutionalized (primarily for mental illness and tuberculosis) for a period of years. With the virtual liquidation of such cases, the caseload in the future will probably involve individuals with lower average ages and more recent onsets of disability. It is generally agreed by the disability experts who testified before the subcommittee that these referrals will possess greater potential for rehabilitation.

Witnesses before the subcommittee also indicated a number of areas where changes were needed to strengthen the rehabilitation aspects of the disability program. Among them were the following:

Extension of the 12-month trial work period to all beneficiaries who seek to rehabilitate themselves

The present law permits a disabled person to engage in substantial gainful activity pursuant to a State-approved rehabilitation plan for a 12-month period without termination of his benefits by reason of such work. Many witnesses appearing before the subcommittee expressed the belief that the ends of rehabilitation would be much more effectively served if this trial work period were extended to other beneficiaries who attempt to rehabilitate themselves.

In his report to the subcommittee on the disability plan, the Comptroller General of the United States made the following recommendation to Congress:

A strong incentive for achieving rehabilitation is denied a disabled worker who attempts a rehabilitation program devised by himself, his family, or friends or conducted under auspices of a non-State enterprise. Under the present law, the 12-month trial work period, during which disability payments are continued, benefits only those individuals who are under State-sponsored rehabilitation plans. This limitation regarding eligible plans does not encourage the maximum number of beneficiaries to return to productive activity.

To encourage the maximum number of individuals to return to productive activity, we are recommending that the Congress consider amending the Social Security Act to afford the protection of a 12-month trial work period to all individuals who attempt a rehabilitation program (hearings, p. 285-286).

In his testimony before the subcommittee on the final day of the hearings, the Commissioner of Social Security, William L. Mitchell, stated:

Among the important issues which were raised during these hearings was the issue of whether there are ways to modify the administration of the disability provisions so as to increase the number of disabled persons who are being rehabilitated. A possibility that offers promise is one which, as Deputy Commissioner Wyman reported, the Department has had under study. I refer to the proposal to provide a trial work period of 12 months during which all the disabled who are rehabilitated may try out their new skills without suffering the disincentive imposed by the threat of immediate termination of benefits. This proposal received the full support of the expert witnesses who testified on the rehabilitation aspects of the program (hearings, p. 958).

Dr. Henry H. Kessler, internationally known in the field of rehabilitation, in answer to a question as to whether the trial work period should be extended to all beneficiaries, stated:

Yes. The principle now being discussed by most of the pension systems throughout the world is giving them financial incentive and rehabilitation service. That is recognized in the international sphere. The man needs an incentive and rehabilitation service (hearings, p. 597).

Miss Mary E. Switzer, Director of the Office of Vocational Rehabilitation, favored this change because—

If a beneficiary is able, through his own efforts or with assistance from agencies other than the public agencies, to rehabilitate himself, we feel that the same trial work period should be allowed. * * * There are always trial and adjustment factors involved and we believe the 12 months' period to be reasonable (hearings, p. 582).

Mr. E. B. Whitten, executive director of the National Rehabilitation Association, stated that his organization—

believes that the law should be amended to assure the continuation of benefits for a liberal period of time to all beneficiaries during and after receiving rehabilitation services and participating in procedures designed to return them to work (hearings, p. 797).

Raymond W. Houston, president of the American Public Welfare Association, wrote the subcommittee on November 6, 1959:

It is highly probable that if it were possible to treat these individuals in a manner similar to those who have received vocational rehabilitation services that even larger numbers would return to work (hearings, p. 814).

And Mrs. Katherine Ellickson, assistant director of the department of social security, AFL-CIO, stated:

The legislation is wise in providing that benefits shall be payable for a year during rehabilitation under the Federal-State program. We would like to see a comparable provision for continuation of benefits for a reasonable time in the case of persons, previously found eligible for benefits, who, through their own efforts or some other program again find employment (hearings, p. 842).

There was no testimony before the subcommittee which was opposed to such a provision.

Elimination of 6-month waiting period for disability insurance beneficiaries who have had a prior period of disability

Under present law, if an individual leaves the disability rolls he cannot return to the rolls until 6 months after the time he has again

been determined to be disabled under the act. The Comptroller General made the following recommendation to Congress:

To require a second 6-month waiting period in reentitlement cases where the applicant's disability is the same or closely related to the original disability is inequitable and also serves to deter rehabilitation.

To strengthen the rehabilitation program and remove an existing inequity, we are recommending that the Congress consider amending the Social Security Act to eliminate the 6-month waiting period for reentitlement cases whenever the following conditions exist:

1. A prior disability period was terminated because the beneficiary engaged in substantial gainful activity despite the continued existence of a severe impairment.
2. The beneficiary is unable to engage in substantial gainful activity at the time a new application is filed under the same or a related disability (hearings p. 287).

There was no testimony in opposition to the elimination of the second waiting period.

Evaluation of rehabilitation potential

Under the interpretation of existing law by the General Counsel of the Department of Health, Education, and Welfare, any costs which may be incurred solely in connection with determining the eligibility or capacity of an individual for rehabilitation cannot be charged to the disability insurance trust fund. Representatives of the State vocational rehabilitation agencies and the National Rehabilitation Association testified they believed that money from the disability insurance trust fund should be made available for the evaluation of the rehabilitation potential of disability applicants and that the Congress intended this when it enacted the disability program.

Mr. Seid W. Hendrix of the Louisiana Rehabilitation Agency testified before the subcommittee that—

The people who operate the State-Federal program of vocational rehabilitation have long felt that rehabilitation potential should be evaluated at the time that disability is determined. In fact, there was a determined effort made to have this included as part of the operation with costs to be paid from the trust fund. It would appear that this is the most economical and certainly the most complete way to determine the exact status of an individual with respect to either his social security payments or his rehabilitation possibilities (hearings, p. 600).

The representatives of the American Medical Association told the subcommittee that their association had no formal position on this matter. It was their opinion, however, that the association would probably be opposed to such a move. If such funds were to be provided, they believed they should come from the regular appropriations for the State-Federal rehabilitation programs rather than the disability trust fund (hearings, pp. 807-808).

As to the question of whether the evaluation of rehabilitation potential would slow the disability determination process, the following colloquy took place between Robert M. Ball, Deputy Director, Bureau of Old-Age and Survivors Insurance, and Mr. E. B. Whitten of the National Rehabilitation Association:

Mr. BALL. * * * What I am saying is that if it were determined to be the proper policy for the trust fund to pay for rehabilitation potential, I would hope that it could be worked out in such a way that it would not further lengthen the time of making disability payments and would be a second step after the determination.

Mr. WHITTEN. Mr. Chairman, we would agree to that 100 percent. We think this ought not to delay the determination of disability but that it ought to be a part of the regular procedure that would be followed whether or not disability

payments may be made before there is a finishing of this evaluation of potential. This might take, in some instances, several weeks. I certainly would agree with that viewpoint (hearings, p. 804).

The subcommittee believes that the Department should institute a study of the desirability and administrative ramifications of providing for the evaluation of rehabilitation potential of disability applicants at trust fund expense. Testimony before the subcommittee indicated that when the disability program was instituted in 1954, and greatly expanded in 1956, there were grave questions of whether this procedure could have been instituted without causing serious delay in disability determinations. Under present conditions, with the backlog of disability cases almost eliminated, it would appear reasonable for the Department to take another look at the feasibility of such a development.

Effect of the disability program on State rehabilitation agencies

In general, the consensus of opinion was that the inauguration of the disability program has had a beneficial effect on the State agencies and rehabilitation in general.

Claud M. Andrews, director of the Florida Vocational Rehabilitation Agency and chairman of the States' council committee on OASI relationships, testified before the subcommittee:

In spite of the many problems involved, a great majority of the vocational rehabilitation agencies and their personnel feel that the disability determination program is adding to vocational and rehabilitation potential, that it is beneficial to their agencies, and that it will have permanent benefits for the Federal and State governments, and especially for disabled individuals themselves (hearings, p. 98).

Replies to the subcommittee questionnaire indicated that a great majority of the State agencies believed that the process of determination of disability had helped their rehabilitation programs. The major reasons given for this conclusion were the following:

(1) The detailed information on medical condition, and specific evidence of work history, education, and skills which is made available to the vocational rehabilitation agency by the disability determination unit. The use of these data not only speeds up the rehabilitation process but also prevents duplication of costs and effort on the part of the applicant, the physician, and agency officials.

(2) An improved and enlarged relationship between the State agencies and doctors, hospitals, and other medical institutions throughout the State which has resulted from the disability program.

(3) The large referral program, or "case finding" system, has given the State agencies the opportunity to render services to many persons—especially in the older age groups—who never would have been known to the vocational rehabilitation agencies.

(4) Increases in staff, prestige, and contacts have resulted from the establishment of disability determination units in the State agencies.

PROTECTION OF THE CLAIMANT'S RIGHTS

Under the law, an individual is required to furnish evidence of his disability (secs. 216, 223). The primary obligation for supporting the claim rests, therefore, with the claimant. *The subcommittee believes that, under these circumstances, the importance of providing each claimant with the kind of information and assistance he needs in preparing his*

claim, and of giving him an explanation of his legal rights and remedies, cannot be overestimated. The average applicant for a social security disability benefit is ill, in many instances he is destitute, and he is usually uninformed as to the content of the social security law. If he is not given effective guidance as to his rights and as to what evidence is needed to support his claim, he may be denied the benefit to which he is entitled. Likewise, without such guidance he may pursue a frivolous or hopeless claim.

Representation and assistance at the district office

Spokesmen for the Bureau of Old-Age and Survivors Insurance testified that their people in the district offices have accepted the obligation of affording the claimant substantial assistance in securing necessary evidence and of providing advice and information during an extensive interview process. These spokesmen further testified that, since the disabled as a group have very special problems, particular effort is made to safeguard their rights.

The subcommittee was pleased to learn from its survey of disability applicants—including both successful and unsuccessful claimants—that the great majority reported that they had been given good, prompt service, and were treated with courtesy in the district office.

Although the subcommittee is impressed with this information, we still believe that the applicant does not always have completely adequate independent advice in making crucial decisions such as whether to file an application or whether to appeal his case if benefits have been denied. This has become more of a problem in the social security program since the passage of the disability provisions which call for more judgment than do the determinations under the provisions for retirement and survivor benefits.

There are three basic questions in this area: (1) Are the district office employees qualified, from a technical standpoint, to give the very necessary expert advice concerning this complicated medical-legal program? (2) Is such advice being communicated to the claimant, particularly at the time his claim is denied? (3) Even if district office employees have technical competency, are they placed in a conflict-of-interest situation which prevents them from giving the completely independent evaluation essential for the full protection of the claimant's rights?

Personnel in most of the social security district offices do not specialize in respect to disability applicants, but have across-the-board responsibility for all phases of the highly complex old-age, survivors, and disability programs. The subcommittee is particularly impressed, therefore, with the arduous and demanding responsibilities which are now imposed upon them in assisting the disability applicant—with his very specialized needs—in the initial filing of his claim and, if the claim is denied, in conducting the explanatory denial interview.

A substantial number of the applicants consulted in the subcommittee survey, while approving of the treatment they had been given at the district office, did not feel that they had been given a full explanation of the program. More particularly, only 60 of the 151 applicants surveyed reported that they had been given any explanation as to how disabled one has to be to qualify for benefits. Those who did state that they were given such an explanation usually said that it was limited to a few words: i.e., the applicant was usually told that his disability had to be sufficiently severe to prevent him from doing any substantial work.

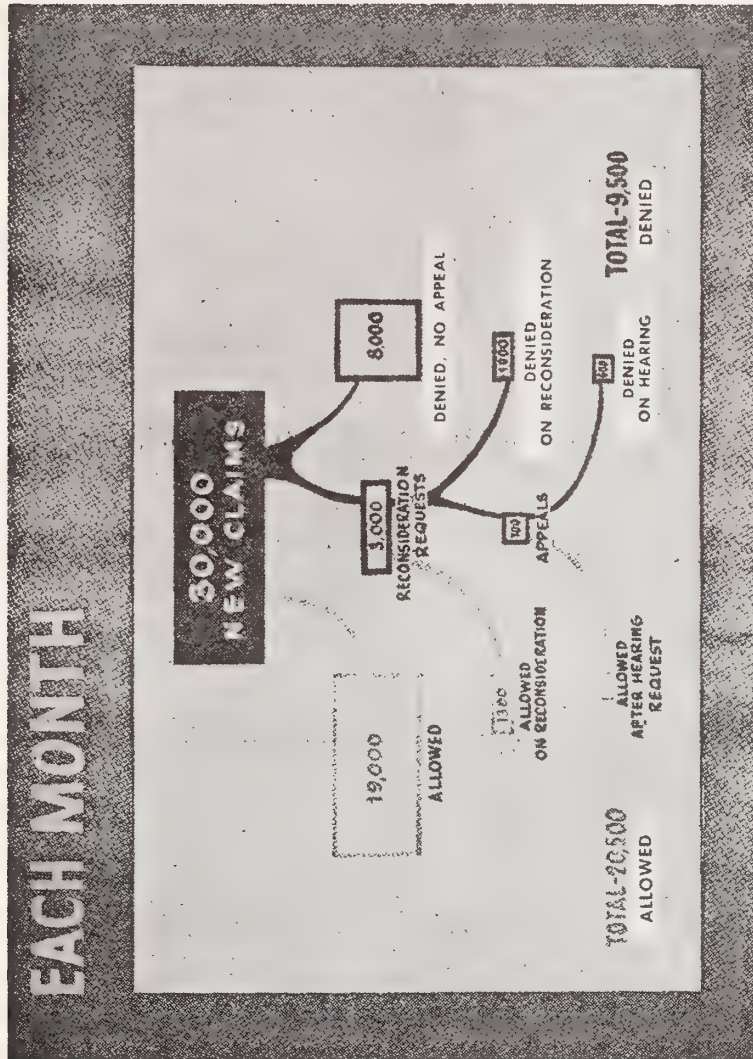
In fairness to the district office personnel it should be stated that the disability program contains concepts which are very difficult to articulate in simple language and in a specific manner. For this reason, we believe that more interpretive guidance is needed from the Department as to the meaning of such phrases as "substantial gainful activity." (Our recommendations in this area are contained in the section of this report entitled, "Disability Definitions and Standards.")

The subcommittee is also impressed with the importance and sensitive nature of the denial interview. Information supplied by the Bureau indicates that about 11,000 persons are denied benefits every month by the State agencies; 3,000 of these persons appeal their decisions and half of them, about 1,500 persons, are ultimately awarded benefits; 8,000 applicants, however, do not appeal. The subcommittee recognizes that the majority of these individuals may have been rightfully denied benefits, but it has a lingering concern that some people in this group might have been awarded benefits if they had appealed.

The so-called "denial letter," sent to every disallowed applicant, is merely a form letter which is not individualized to any degree with respect to the particulars of the given case, and gives little, if any, of the reasons for the denial contained in the written determination of the State agency. All the claimant gets is the invitation in the last paragraph of the letter: "If you have any questions, please call at the district office shown above and take this notice with you."

The subcommittee was concerned with the information elicited from the claimants in our survey which showed that only 9 out of 56 persons who had been denied a benefit, and had not appealed, went into the district office to find out why their claim had been denied. A great majority of these applicants stated that they were dissatisfied with the decision, but a fairly substantial number had adopted a "what's the use" attitude. *We believe that many misconceptions about the program could be cleared up and that the claimant's rights would be more adequately protected if better means could be found at this point to communicate the rationale underlying the complex medical-legal State agency determination to the claimant. It would also pinpoint where his evidence did not meet the requirements of the act, and assist him in exploring the possibility of developing further evidence to meet this deficiency.*

The final question is whether the people in the district office, regardless of their competency, can wear the "two hats" of their position—that of protector of the claimant's rights and protector, as well, of the disability trust fund. These people are the employees of the Bureau and are presumably following the Social Security Administration's interpretation of the law and its regulations. Commissioner Mitchell stated at the hearings that "the disposition and training that has permeated our whole organization from the beginning is one that is designed to make sure that people get their rights" (hearings, p. 978). The question remains, however, whether claimants' rights are always just what the Social Security Administration says they are. A number of court cases would indicate the contrary.



Representation at the hearings

The subcommittee believes that substantial assistance must be supplied to disability claimants if their rights are to be protected during the complicated appeals procedure. This is particularly true at the hearing.

Of the claimants interviewed who had hearings one-third stated that they had not been told that they could have someone represent them at the hearing. In our survey of the 110 social security hearing examiners, the majority stated that the help available to claimants, from all sources, was not adequate. A substantial number of those who said it was adequate took the position that its adequacy was due primarily to the assistance rendered by the examiner himself.

Nearly all examiners who commented on the point noted that claimants are infrequently represented by counsel—counsel appear in about 20 to 30 percent of cases—and that, when they do appear, they are often unfamiliar with the program and inadequately prepared. The reason most often given for the inadequacy of counsel was the low fees fixed by regulations. Since 1940 the fee has been fixed at \$10 although higher fees may be allowed on petition. However, a regulation to fix the fee at \$30 for the Hearing and Appeals Council has just been put into effect. During the subcommittee hearings, Earl W. Kintner, Chairman of the Federal Trade Commission, representing the administrative law section of the American Bar Association, commented on the possible effect of this low fee in the following colloquy:

Mr. HARRISON. * * * I understand the regulations still provide for a \$10 fee but under special circumstances an attorney may petition for a larger fee. The supreme court in my State of Virginia has said that a lawyer's services are worth what they are paid for. Would you generally agree with that?

Mr. KINTNER. I certainly would. I do not know what level of legal service could be obtained in these days for \$20.

Mr. HARRISON. In a \$7,500 case, it would certainly be more than that?

Mr. KINTNER. There are two possibilities here: either the fee might be increased or the restriction might be lifted entirely (hearings, p. 904).

The subcommittee hopes that the new, still relatively low, fee schedule will increase the frequency and quality of representation.

The fact that the hearing examiner must exercise three functions—that of adjudicator, investigator, and protector of the claimant's rights—has been called to the subcommittee's attention. Our survey of examiners showed that the majority believe they cannot adequately perform all three functions at once. Some also question the legality of this combination of functions in view of the requirements of section 5(c) of the Administrative Procedure Act—the "separation of functions" section. Many examiners feel this problem could be relieved to some extent if there were a Bureau representative at the hearing. This, they believe, would relieve them of any duty to cross-examine claimants, and thus increase the appearance of fairness at the hearing. However, many examiners feel that such a procedure should not be instituted unless adequate representation could also be provided for claimants.

The subcommittee is aware of the fact that claimants under other Government disability programs, such as the railroad retirement and Veterans' Administration systems, do have independent advice and assistance available to them in processing their claims. For example, in claims for disability allowances under the Railroad Retirement Act,

a company doctor who is well versed in the requirements necessary for disability evaluation, prepares the initial papers for the claimant. In cases before the Veterans' Administration, representatives of the several veterans' organizations are available to the claimant to help him in preparing and prosecuting his claim. Testimony before the subcommittee indicates that organized labor is supplying some independent claims service to social security applicants but this service is not all-inclusive even for their own membership. The subcommittee claimant survey also indicates that some State public assistance agencies are supplying assistance in this regard.

Problems in appeals procedure

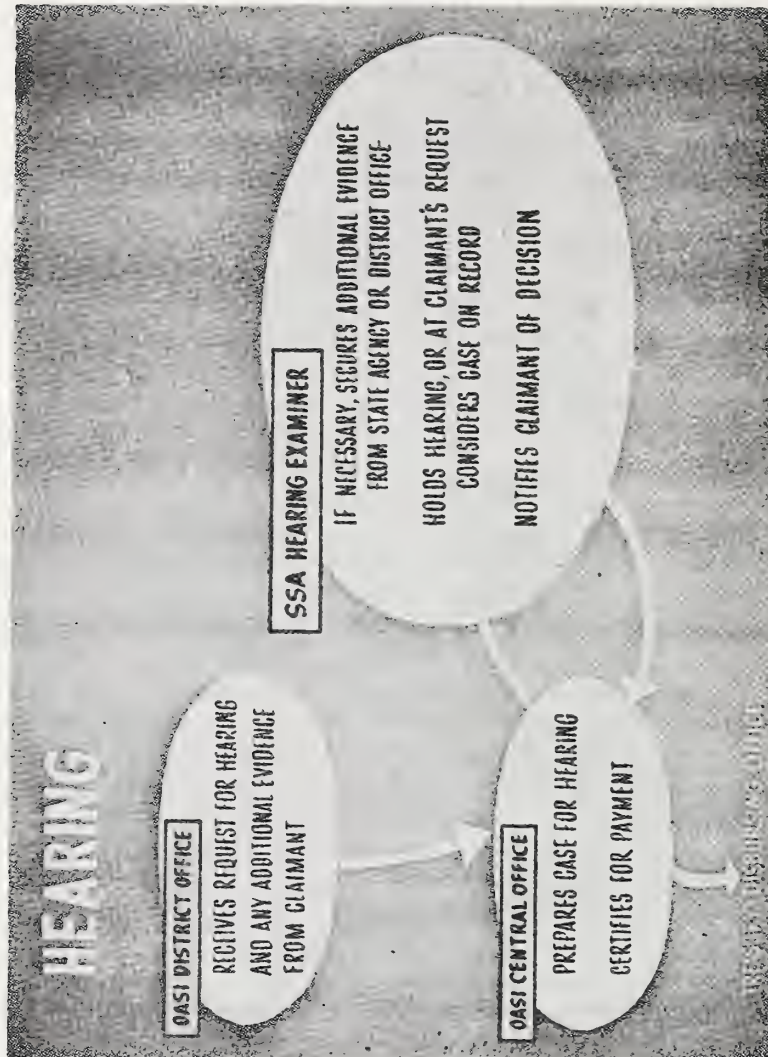
A claimant who is dissatisfied with the initial decision in his case may request that it be *reconsidered* by the State agency. If the reconsidered decision is also adverse, he may request a *hearing* before a hearing examiner appointed under the provisions of the Administrative Procedure Act. If the hearing results in a denial of the claim, claimant may request review of that decision by the Appeals Council. If the Appeals Council affirms the denial, the claimant may seek judicial review in a Federal district court.

The present procedures are based on the provisions of the Social Security Amendments of 1939 and, in large part, on the recommendations of a group of experts on administrative law who studied the system at that time. The basic appeals procedure and regulations have changed very little since 1940. The subcommittee understands that a similar study is being initiated at this time.

During the 20 years that these procedures have been in effect a number of significant developments have taken place. One was the passage of the Administrative Procedure Act of 1946 which covers, under its provisions, the type of hearings contemplated in section 205(b) of the Social Security Act. A second was the great upsurge in appeal activity which was occasioned by the passage of the disability provisions in the Social Security Amendments of 1954, 1956, and 1958. Requests for hearings, for instance, increased 512 percent in 3 years, from 3,800 in 1955 to 23,250 in 1958. The number of hearing examiners on duty rose from 30 at the end of 1956 to a peak of 145 in February 1959. There are 110 today. Likewise requests for reconsideration jumped from 13,500 in 1955 to 92,664 in 1958.

Before proceeding further, it should be stated that, by and large, the subcommittee is satisfied that the Social Security Administration has done an admirable job in handling the "appeals crisis" occasioned by the disability provisions. The subcommittee believes that the great majority of hearing examiners are performing an exceedingly difficult task with tact and competency. Our random survey of disability applicants who have had hearings shows that the great preponderance believed they had been treated courteously and afforded a fair hearing. This is true even though a great many were not satisfied with the result in their case.

The subcommittee feels, however, that the administration of a program which touches the lives of more ordinary citizens than any other Federal program must, like Caesar's wife, be above suspicion. That is, procedures must not only be fair in substance, there must be no appearance or suspicion of unfair practices. We believe that the best way to create this atmosphere is to operate within the letter and spirit of the minimum



procedural requirements which have been established by Congress. It is important that the procedural safeguards of claimants not be corroded by well-meaning action in the name of uniformity or administrative efficiency.

Some of the questions which are raised in this report are ones upon which reasonable men may differ. But the subcommittee believes they should be thoroughly aired at this time when the press of the backlog emergency has been substantially reduced.

Reconsideration.—In the past, an applicant who had been denied a benefit by the State agency had the option of either requesting a reconsideration by the State agency or of requesting a hearing before an examiner. Last September, a regulation went into effect making reconsideration mandatory before a hearing. The Social Security Administration's justification for this regulation was that the relief sought would be obtained with less cost and delay. The subcommittee has felt some concern over the number of levels of review in this program. This regulation makes another one mandatory. The representatives of the Department testified that, in their judgment, the many reviews and re-reviews are necessary in order to insure reasonable uniformity in the operation of a nationwide program. But the question of whether a claimant becomes exhausted in the process of exhausting his administrative remedies is always a real one.

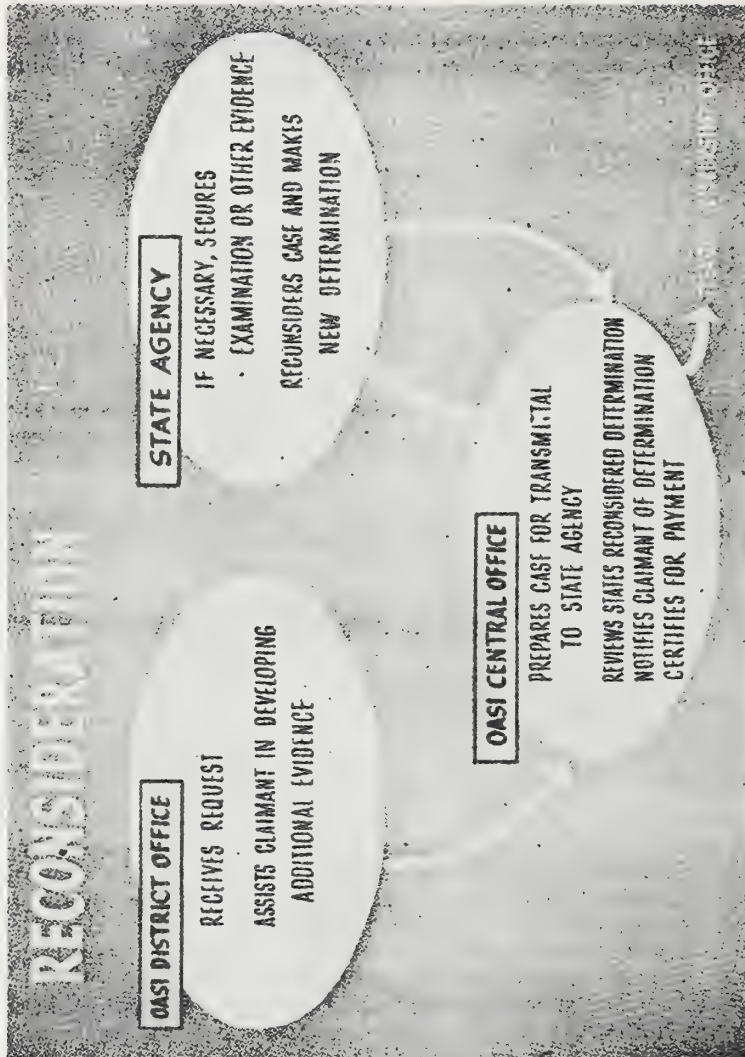
The subcommittee believes it is particularly important that an individual desiring a hearing should not be required to go through the reconsideration process if it means a substantial increase in overall processing time and, with this in mind, we request that the Department watch the process of mandatory reconsideration very closely and report to the committee on its operation.

A number of hearing examiners in the subcommittee's survey questioned the legality of a mandatory reconsideration inasmuch as section 205(b) of the Social Security Act states:

Upon request by any * * * individual * * * who makes a showing in writing that his or her rights may be prejudiced by *any decision the Secretary has rendered*, he shall give such * * * individual reasonable notice and opportunity for a hearing with respect to such decision, and, if a hearing is held, shall, on the basis of evidence adduced at the hearing, affirm, modify, or reverse his findings of fact and such decision. [Emphasis supplied.]

This contention appears to be worthy of further study. It should be noted that, at the reconsideration level where new evidence is frequently submitted, the claimant is not allowed to see the initial determination or the evidence upon which it is based; but, upon request, can get summaries prepared by the Bureau. At the hearing stage, on the other hand, the claimant or his representative is entitled to look at the determination and pertinent parts of the record.

Hearings.—The subcommittee study and the survey of hearing examiners indicate that numerous materials are available to the hearing examiner which are not available to the claimant or his representative. These include the confidential State manual (referred to earlier in the discussion of the disability standards) memorandums from the Office of Hearings and Appeals of a broad policy nature or commenting on specific cases, General Counsel's opinions, and decisions of the Appeals Council.



The survey reveals some disagreement among the hearing examiners as to whether these materials are merely advisory or are supposed to have a binding effect on the hearing examiner. Some examiners, however, feel that failure to follow them may invite reversal. The phraseology of the memorandum is often such that it would appear that more than advice is being offered. In one such memorandum, entitled "Unfavorable Decisions of the U.S. Court of Appeals for the Seventh Circuit in *Teeter v. Flemming*," (hearings, p. 719) examiners were instructed to "adhere to the established departmental position" in spite of the decision in the case in question. The memorandum concluded, "Although more formalized advice will be given at a later date, the foregoing should be put into effect immediately."

The Commissioner testified that the Social Security Administration plans to expand its regulations in this area, that the publication of precedent rulings and decisions has been ordered, and that the publication of selected appeals council decisions is under consideration.

It appears to the subcommittee that the Administrative Procedure Act and basic considerations of fairness call for the publication of all precedent material. This should include so-called training materials which could affect the content of hearing examiner decisions. The subcommittee believes that it is essential to a fair hearing that the Bureau, hearing examiners, and claimants read from the same book.

Until recently examiners have been provided with "summaries of action" prepared by the Bureau. These have been described by a number of hearing examiners as "briefs" for the Bureau. These materials were not made available to the claimant or his representative. The survey team which studied the reorganization of the Appeals Council and the Bureau considered preparing the summary of action "in such style, arrangement, and content that the substance and, in some cases the language (with perhaps some minor revisions) could be bodily converted into the referee's own decision" (hearings, p. 712). The subcommittee is happy to learn that the use of summaries of action has now been dispensed with in all disability cases, and hopes that such undesirable devices will not be reinstated in the future.

In addition to the materials referred to above, hearing examiners have been provided with "medical consultants" under contracts with the Office of Hearings and Appeals. The duties of these medical consultants are specified in the contract:

To examine and comment on medical issues involved in disability hearing cases pending before hearing examiners of the Office of Hearings and Appeals as requested (hearings, p. 724).

The specified compensation is \$10 for each case examined and commented upon.

The opinions and comments of the consultants do not appear on the record of the hearing. In fact, the record does not indicate that such a consultation has been had. The representatives of the Department testified that these consultants are valuable for training purposes in helping examiners deal with difficult problems of medical evidence. However, the present method by which such consultants are used may conflict with section 5(c) of the Administrative Procedure Act, which states in part—

Save to the extent required for the disposition of ex parte matters as authorized by law, no such officer [hearing examiner] shall consult any person or party on any fact in issue unless upon notice and opportunity for all parties to participate. * * *

The Social Security Administration has advised the subcommittee that examiners will be "instructed" to use medical consultants for the following purposes:

- (1) for advice as to questions which should be asked at a hearing;
- (2) for information as to the type of details of a consultative examination;
- (3) for training sessions occasioned by a number of cases involving the same or similar impairments to be attended by all hearing examiners in the particular office.

Otherwise, the Commissioner advises that analysis and comment by medical consultants will be made part of the hearing record.

It is the conclusion of the subcommittee that such instructions if carried out would not answer all objections. The essential problem in the proposed instructions is that they would continue to allow close association between the examiner and the consultant in regard to specific cases. When the consultant can urge a particular line of questioning, or urge that certain types of evidence be obtained it is fiction to say he is not in a position to influence the examiner's decision. Further, so long as this association between examiner and consultant is not a matter of record, it will be impossible to determine whether the "consultation" has stayed within prescribed bounds. *Therefore, the subcommittee is of the opinion that such medical consultants should be used in only two ways—(1) in general training sessions involving general questions and a group of examiners, or (2) as witnesses whose testimony appears in the record, or which can be made part of the record at the request of the claimant after notice in the record.*

The subcommittee was concerned by the use of "temporary" hearing examiners recruited from the Bureau under a temporary suspension of the full requirements of the Administrative Procedure Act. In view of the tremendous backlog of cases awaiting hearings, this action may have been necessary. As a matter of principle, however, it does not seem desirable that hearing examiners be taken from the agency whose decisions they are reviewing and to which they will ultimately return. *The subcommittee is, therefore, gratified to learn that all these examiners will be separated from the staff by the end of the fiscal year and that such authority will not be requested from the Appropriations Committee in the future.* We have no reason to believe that the "temporary" examiners have treated claimants unfairly, but agree with the American Bar Association testimony that the principles of the Administrative Procedure Act should not continue to be disregarded through annual exceptions to its provisions.

The subcommittee is also concerned by the recent reorganization of the Office of Hearings and Appeals which was the result of a management survey conducted last year. As stated previously, we are aware of the tremendous workload problem which has faced this Office, but the subcommittee believes that solutions to these problems cannot be worked out by efficiency experts alone, and that the safeguards for fair hearings which the Congress has provided must be given fuller recognition.

The subcommittee agrees with the American Bar Association and a large number of hearing examiners that a supervisory superstructure such as embodied in the newly created regional hearing representa-

tives, can always be used to exert pressure on hearing examiners who have disregarded unpublished precedent material and policy directives or otherwise "fallen from grace." Mr. Earl Kintner testified:

The American Bar Association, unlike this subcommittee, is not equipped to gather the facts upon which to base a conclusion as to whether, in reality, unwarranted attempts have been made to interfere with the independence of these hearing examiners. But, based upon our study of the recent reorganization and upon other evidences which we have encountered, we believe the situation is sufficiently serious to justify us in alerting this subcommittee to the possibility that actions have been taken which could inevitably result in undue interference with these hearing examiners (p. 875).

Some examiners, in their reply to the subcommittee survey, alleged that they were subject to administrative interference in a variety of forms, including withholding of pay, assignment of cases, failure to approve necessary travel expenses, denial of adequate staff, and undue regulation of mail and telephone service. Most examiners indicated that they had experienced no interference, but many expressed concern about possible interference in the future under the new administrative setup.

The subcommittee passes no judgment on the validity of these charges. However, we feel that they clearly demonstrate the serious potentialities of increased supervision of this kind.

The activities of the regional hearings representative also include fixing "production quotas" and distributing charts which compare the production records of the various examiners. The subcommittee believes that overemphasis on productivity can be harmful to the concept of a full and fair hearing.

In addition to this administrative supervision, the examiners pointed out that they are also given "substantive guidance"—a term used in the regional hearings representative's job description (hearings, p. 726). This "guidance," they state, takes the form of sitting in on cases, and reviewing and commenting on decisions.

As we have already noted, the Office of Hearings and Appeals distributes memorandums to hearing examiners commenting on substantive aspects of their decisions. Such memorandums are objectionable not only because they are unpublished, but also because they do not contribute to an atmosphere of independence in the decision-making process (hearings, pp. 721, 723, 728, and 879). Requests from that Office to see "your next four disability decisions * * * for consideration and comment before release" seem even more serious (hearings, p. 723). Other instances of this type of "guidance" were noted:

We strongly suggest that you use the attachments fully quoting the pertinent provisions of the law and other items as provided in P[olicy] M[emorandum] 18 (Revised). The use of these attachments has the advantage of giving the exact language of the act as well as avoiding any suggestions that a material part was not included, or that the paraphrasing was not accurate (hearings, p. 722).

This attitude is also illustrated by the memo on the *Teeter* case, previously noted, which states that the hearing examiners "should cite the *Spaulding* case as the authority therefor and make reference to the position taken by the American Medical Association" and continues:

You have received Appeals Council decisions which give you acceptable paragraphs pointing out the wide variety of standards encompassed in varied workmen's compensation statutes, veterans statutes, insurance contracts, etc., which are commonly called "permanent and total disability" or "inability to engage in any substantial gainful activity" (hearings, pp. 720-721).

These kits of materials would seem to reflect on the independence of the hearing examiner and to suggest that the people in the Office of Hearings and Appeals believe it is their function to provide the examiners with what they believe are the pertinent legal materials.

The subcommittee notes that the Civil Service Commission's requirements for a hearing examiner are quite extensive: a minimum of 5 years' special qualifying experience as a trial lawyer, judge, or hearing officer, including participation in judicial proceedings of courts of record and proceedings under the Administrative Procedure Act. A man of this caliber, presumably, would be capable of performing his own legal research.

Some degree of training and administrative supervision of the examiners is undoubtedly necessary, but great care must be taken to exercise these functions in a manner and in areas which will not interfere with the examiners' freedom to decide the cases before them.

Review by the Appeals Council.—If a claim is denied by the hearing examiner, claimant may seek review by the Appeals Council. The Council may or may not decide to review. Refusal to review operates as an affirmance of the prior denial. If the hearing examiner allowed the claim, the Appeals Council may assert jurisdiction and review the examiner's decision on its own motion. This is usually done at the request of the Bureau. In any case, the Appeals Council may accept new evidence whether such new evidence is adverse to the claimant or submitted by him.

Two main issues have presented themselves to the subcommittee: (1) whether the Appeals Council properly limits the scope of its review of hearing examiner decisions; and (2) whether the present method of Bureau "appeal" is proper under the Administrative Procedure Act.

As to the first issue, the Appeals Council has taken the position, and is supported in this by the regulations, that when it is reviewing hearing examiner decisions it has authority to take any new evidence it considers necessary, and issue revised findings of fact. Indeed, it may completely bypass the hearing examiner by removing the case from his jurisdiction.

The Appeals Council maintains that it may undertake this hearing function because it is the "agency" under section 7(a) of the Administrative Procedure Act. This section provides in part—

There shall preside at the taking of evidence (1) the agency, (2) one or more members of the body which comprises the agency, or (3) one or more examiners appointed as provided in this Act * * *.

On the other hand, certain hearing examiners have maintained that the Secretary is the "agency" because the Social Security Act gives him the authority to hold the required hearings. Moreover, the members of the Appeals Council are not "examiners appointed as provided" under the Administrative Procedure Act. These individuals cite *Borg-Johnston Electronics, Inc., v. Christenberry*, (169 F. Supp. 746 (S.D.N.Y., 1959), which states:

The Administrative Procedure Act does not forbid the delegation of power to preside at formal proceedings, but specifies that, if this function is to be delegated, it must be to one appointed in a designated manner (at p. 755).

Apart from the correctness of either of these views, the subcommittee believes it is important that the basic hearing functions should be carried out, whenever possible, by an examiner appointed under the provisions

of the Administrative Procedure Act. In the interest of affording the claimant the most convenient forum for the presentation of his case the Appeals Council should, as far as possible, limit itself to a basic review function. In this regard, the subcommittee is impressed with the following quotation from the House report on the bill which became the Administrative Procedure Act:

* * * The examiner system is necessary because agencies cannot themselves hear all cases. Where they do not do so some device must be used to bridge the gap between the officials who hear and those who decide cases. The provision that on agency review of the initial examiners' decisions it has all the powers it would have had in making the initial decision itself does not mean that initial examiner's decision or recommended decisions are without effect. They become a part of the record and are of consequence, for example, to the extent that material facts in any case depend on the determination of credibility of witnesses as shown by their demeanor or conduct at the hearing. In a broad sense the agencies' reviewing powers are to be compared with that of the courts under section 10(e) of the bill (H. Rept. No. 1980, 79th Cong., to accompany S. 7). (See "Legislative History of the Administrative Procedure Act," S. Doc. No. 248, 79th Cong., at pp. 272-273.)

Bureau "appeal"

When a hearing examiner has reversed a Bureau denial, it is then studied by a special Bureau unit. If this unit is dissatisfied with the examiner's decision it requests (often by telephone) that the Appeals Council review the case on its own motion. The fact that the Bureau has "appealed," and its grounds and contentions are never noted in the record or made available to the claimant.

Furthermore, when there is disagreement between the Bureau and the Appeals Council as to the proper resolution of a case, it is worked out by negotiation between the Bureau and the Appeals Council without notice or opportunity to participate being given to the claimant. The claimant is unaware of such proceedings until he receives notice that the Appeals Council is reviewing the case on its own motion.

Even if it is decided that the Appeals Council will not review on its own motion, the hearing examiner is likely to be informed of the Bureau's position. See, for instance, the following memorandum from the Appeals Council to a hearing examiner, quoted in the subcommittee's hearings:

We feel that your decision is in the upper limits of liberality, according to our present concepts, but we are not going to refer it to the Appeals Council for review on its own motion. * * *

The Bureau has protested your decision, but we have asked them to effectuate the finding * * *

These matters have been called to your attention for your consideration and guidance in future cases (hearings, pp. 721-722).

We believe that these practices should be examined in the light of section 5(c) of the Administrative Procedure Act which states in part—

No officer, employee, or agent engaged in the performance of investigative or prosecuting functions for any agency in any case shall, in that or a factually related case, participate or advise in the decision, recommended decision, or agency review pursuant to section 8 except as witness or counsel in public proceedings.

When the Bureau seeks to have the Appeals Council reverse an allowance by an examiner, it may well be "prosecuting" or "participating in the decision" within the meaning of the quoted statute.

Quite apart from the provisions of the Administrative Procedure Act, the subcommittee believes that more attention should be given to the view which was taken in the 1940 report, "Basic Provisions adopted by the Social Security Board for the Hearing and Review of Old-Age and Survivors Insurance Claims * * *" which states in part:

It has been suggested that the Bureau * * * might be entitled * * * to take an appeal wherever, upon review of the referee's decision, it felt that a different conclusion should have been reached. While precedent for such an arrangement can be found under some systems of administrative appeals, it is believed that the Appeals Council, being established outside the bureau and exercising authority delegated directly to it by the Social Security Board * * * and having, therefore, no reason to defend an unfavorable conclusion reached by the bureau but only a purpose to "do justice" to the claimant in accordance with congressional intent as embodied in law, could review referees' proposed favorable decisions in a thoroughly unbiased manner upon its own motion. (Reprinted as appendix to Monograph No. 3 of the Attorney General's Committee on Administrative Procedure, S. Doc. 10, 77th Cong., 1941, at p. 52.)

If, however, Bureau appeal is deemed necessary in order to insure uniformity among the hearing examiners, such Bureau participation should be noted in the record. We feel that a short summary of the Bureau's contentions could be included without causing any great administrative difficulties, and that such a summary would alert claimants to the issues to be considered by the Appeals Council.

Judicial review

When a claimant has exhausted all of his administrative remedies, he may seek judicial review in a Federal district court. There are two limits on the power of the court. First, the court must, under section 205 (g) of the Social Security Act, remand the case for further administrative proceedings if the Secretary so requests. Second, the court cannot accept new evidence and is bound by any administrative findings of fact which are supported by substantial evidence.

Since the advent of the disability program there has been a sharp increase in the number of social security claimants going to court. This trend has accelerated in recent months. While such cases do not represent a large proportion of the total number of claims filed, the absolute number is large and increasing.

The problems concerning court review grow out of the statutory limitations on the court's jurisdiction mentioned above.

Under section 205(g) of the Social Security Act, the district court must remand for further administrative proceedings on motion of the Secretary if he has not filed his answer. As of October 30, 1959, the Secretary had requested remand in 123 (or 27 percent) of 456 civil actions filed. In most of these cases remand is requested for the purpose of taking new evidence. There are at least three situations in which the Secretary may feel the need of new evidence. First, the Appeals Council frequently denies a claimant's request for review (and thereby affirms the prior denial) by relying on the hearing examiner's opinion, without looking at the full record in the case. Second, in some instances it appears that the Appeals Council does review a case on the full record, but affirms the prior denial where it is aware that the record is or may be insufficient to sustain judicial scrutiny. Third, it appears that some remands are for the purpose of insuring that the record reflects the most recent decisions and attitudes of the Court which is to hear the case.

The subcommittee is not convinced that this practice is wholly fair to the claimants involved. We believe that the full committee may wish to consider the advantages of making remand on request of the Secretary discretionary with the court, on the same basis as if requested by the claimant; that is, where there is some showing that there is new evidence which is material, and that there is good cause for the failure to incorporate it in the record prior to court review.

The subcommittee realizes that under any procedure there will be cases in which further administrative proceedings are proper, whether requested by the claimant or the Secretary. We are, however, concerned with the amount of time consumed in handling remanded cases. As of October 30, 1959, the Appeals Council had acted in only 40 of 123 remanded cases, 15 of which were still awaiting final action by the courts.

The so-called "substantial evidence" rule is the second major limit upon the court's power to review administrative determinations. This rule is contained in section 205 of the Social Security Act, and section 10 of the Administrative Procedure Act. It, therefore, extends to all proceedings held by agencies covered by the Administrative Procedure Act, and is not restricted to social security cases. During the course of the hearings held by the subcommittee, concern was voiced as to whether the courts were violating the rule by undertaking to make independent judgments as to the balance of the evidence in disability cases. The following testimony was elicited from Harold P. Packer, Assistant General Counsel, Department of Health, Education, and Welfare:

Mr. HARRISON. If it became the general procedure of the courts to readjudicate the case on its merits, it would seriously affect the cost of this program.

Mr. PACKER. Unquestionably so. I am sure that we as a Department would be extremely alert to that, and if we felt the rule of law was being decided otherwise, in other words, the courts were merely giving lipservice to the rule and then reappraising all the evidence, it would unquestionably be called to the attention of the committee perhaps for further legislative action.

Mr. HARRISON. You have not reached that point.

Mr. PACKER. I do not think so, because we have only two court of appeals decisions involving disability cases. In those two court of appeals decisions, one of them, in the second circuit, clearly upheld the decision of the lower court which in turn turned precisely on the substantial evidence rule.

The other court of appeals case which upheld a reversal of the Department seems to indicate some reappraisal of the evidence, but of course we feel there might have been other errors in the decision which might have motivated the court in going the way it did (hearings, p. 701).

Section 205(g) of the Social Security Act reads in part as follows:

The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Secretary * * *, because of failure of the claimant * * * to submit proof in conformity with any regulation prescribed * * *, the court shall review only the question of conformity with such regulations and the validity of such regulations.

The jurisdiction of a court to review a determination of the Secretary is limited to a review of the record made before the Secretary. It is not a trial de novo but is limited to a consideration of the pleadings and the transcript of the proceedings at the hearing. The court has no power to hold a hearing and determine the merits of the claim because the statute makes it clear that the determination of claims is solely a function of the Secretary.

Sections 216 and 223 of the Social Security Act require that claimants establish the existence of disability by such proofs as the Secretary may prescribe. The Secretary has not seen fit, however, to publish these requirements in the form of regulations to any degree. In contrast to the detailed regulations pertaining to the establishment of regular old-age and survivors insurance claims, the disability regulations (20 CFR 401.1501) state only that impairment must be shown by "medical evidence, and where necessary by appropriate medical tests." Although the confidential manual specifies the tests which are deemed appropriate, the instances in which they are necessary, and states that the evidentiary requirements are not met by submission of opinions by doctors on the ultimate issue of disability, these materials are not available to the claimants and the courts. Even these guides do not spell out the types of evidence, if any, which should be submitted in order to prove the existence of the so-called "nonmedical" factors. Looking at the situation in this context, some of the courts which seem to be relaxing the "substantial evidence" rule may, in reality, be wrestling with the problem of insufficient regulations as to burden of proof.

The subcommittee wishes to emphasize that before the courts can be expected to apply the substantial evidence rule it must be clear that the administrative process has been conducted in such a manner that the claimant has been afforded a full and fair hearing as required by law.

Location of Office of Hearings and Appeals.

The Office of Hearings and Appeals is a part of the Office of the Commissioner of Social Security. The Secretary of Health, Education, and Welfare has delegated authority directly to the Office of Hearings and Appeals relating to the holding of hearings and rendition of decisions. Administratively, the Office of Hearings and Appeals is responsible to the Commissioner of Social Security and its decisions are made in accordance with his applicable policies, rules, and regulations. For budget purposes, its appropriation comes under the budget of the Bureau of Old-Age and Survivors Insurance. The question arose at the subcommittee's hearings whether the Office of Hearings and Appeals should be transferred outside of the Social Security Administration:

Mr. HARRISON. If we are to dignify this record as we want to dignify it, as complying with the due process requirements and requiring the courts to apply to it the substantial evidence rule, I am wondering if these people who make those adjudications should be characterized as "our people." What would you think of transferring the Office of Hearings and Appeals to the Secretary's Office, which would completely divorce it from any control of your agency and protect its independence?

Mr. MITCHELL. I would oppose that unless there were some factual demonstration of a need for it. If there were a factual demonstration, then I certainly wouldn't be so bureaucratic as to stand in the way of any such needed reform.

I would strongly recommend, however, Mr. Chairman, that this be one of the topics that we identify for special emphasis in this substantive review process that we are proposing to have made and have that particular problem commented upon by one or more of the outstanding experts in the field, some of whom we have already had assist us in the setting up of our original procedures and who have subsequently reviewed them at one time or another (p. 978).

PURCHASE OF MEDICAL EVIDENCE

One of the more important aspects of procuring evidence on a disability claim is the purchase by the Government of medical examinations (known as consultative examinations) by specialists after the individual file has been sent to the State agency. Under present Bureau operations, these examinations are ordered only after the individual has submitted sufficient evidence to show there is a reasonable likelihood that his impairments meet the disability requirements set out in the law. They are now purchased in about one-third of the cases initially received by the States and in additional cases involving other actions such as investigation of continuing eligibility. Moreover, the amount of money spent on such examinations is nominal when compared to the amount of benefits that can be paid over the years in a case—an average of \$7,500 and even as much as \$15,000.

These examinations, in some cases, serve the purpose of protecting the trust fund from unwarranted claims. In other cases they serve the purpose of helping to establish a claim by assuring that the severity of an applicant's impairment is fully apparent. The evidence in a case may be sufficient, standing alone, to establish the reasonable likelihood of disability, but the adjudicator may have some doubt that the decision based on such evidence would be a proper one. There may also be situations where there are conflicting findings in several reports.

In other instances the claimant may not be able to produce the type of evidence necessary to make a determination in his case, although the evidence presented shows a reasonable likelihood of disability. This occurs where the attending physician has sufficient information to determine the course of treatment, but not enough information to determine the extent of the individual's impairment. For treatment purposes, it may not be necessary for the attending physician to conduct specialized tests, while for the purposes of determining a disability, further information is necessary to determine the extent of the patient's loss of function or his capacity to work. Here, too, a specialist's examination permits a prompt and proper adjudication of the claimant's case.

The subcommittee requested that the General Accounting Office give its views as to the authority of the Bureau to purchase consultative examinations. The Associate General Counsel of that Office testified to the legality of the current practices and, in fact, indicated that the Secretary may have authority which is broader than the practices now exercised by the Bureau (hearings, pp. 769-772).

The subcommittee finds that the provision for consultative examinations is clearly an essential element of the process of developing evidence and determining disability.

Representatives of the American Medical Association and other medical experts in testifying that the Bureau's approach to consultative examinations is sound, also suggested that these examinations should be obtained from the claimant's own physician in certain cases. Dr. Charles L. Farrell, representing the American Medical Association, said at the hearings:

We believe, however, that when additional medical data is needed for a sound determination, such further information should be obtained from the claimant's own physician, if possible, in a similar manner to the way it is now obtained

from a consulting physician. BOASI should be authorized to require the State agency to make arrangements with the medical profession in the respective States that will permit them to purchase these supplementary examinations, laboratory, or other tests from such physicians and under such circumstances as to promote further doctor-patient relationships and rapid development of comprehensive information (hearings, p. 784).

Further amplification of this proposal was elicited by subcommittee questioning. The following colloquy took place:

Mr. METCALF. I have a client who gets into an accident. He comes in and makes a claim for an injury to his back. His family physician says he is permanently disabled, so I sue * * * (an) insurance company. If you were the attorney defending the insurance company would you take only the claimant's family doctor, or would you want to have an independent examination by some other physician?

Dr. FARRELL. Naturally you would want an independent examination. I did not mean to imply that the family doctor would be the only source of the supplementary data. I meant if the case were such that the Department felt he had presented sufficient evidence, and that all he needed to help make a determination was supplementary data which the family doctor was able to supply but the patient might have been unable to get.

Mr. METCALF. I understand. If it were just a matter of taking an additional test or some matter had been omitted, or if some further evidence were needed; rather than a claim in conflict situation (hearings, pp. 785-786).

The Department was not prepared to testify at the hearings on the AMA proposal, but a Bureau spokesman did point out that some substantial problems might arise in developing criteria which would determine the conditions under which examinations could be purchased from the claimant's attending physician. *The subcommittee believes that the advantages and disadvantages of this proposal should be thoroughly explored by the Department and that appropriate administrative action should be taken if the purchase of supplementary medical evidence from attending physicians, under specified circumstances, serves the best interests of the disability program.*

The question also arose during the hearings as to who should bear the cost of obtaining an initial medical examination, and whether the cost of obtaining this evidence should not, in some cases at least, be paid by the Department. The representative of the American Medical Association, Dr. Farrell, stated that it is opposed to the purchase of such an examination for the applicant. The following colloquy took place at this point:

Dr. FARRELL. I think our position is quite clear. The initial examination under the law, and we concur, should be the responsibility of the applicant. I he is unable to pay for it I am sure his physician will supply the information available free of charge, or there are enough places elsewhere for a record to be kept. This is the responsibility of the applicant and we agree that is sound policy.

Mr. HARRISON. Suppose he cannot get this evidence?

Dr. FARRELL. I cannot quite conceive of a situation where he has been treated by someone and the information is not available.

Mr. HARRISON. There has been considerable evidence before us, by Dr. Grant (Dr. Harry E. Grant, chief medical consultant, disability determination section, Division of Vocational Rehabilitation, State of Illinois) and others, that claimant cannot get that information. The family physician has not seen him for several years, he has no money, and thus he is in no position to get that information.

Suppose he were obligated to pay for it in the event his claim were approved? What would be your position in that situation?

Dr. FARRELL. In an isolated instance it might be difficult to explain. We are talking on the basis of the principles involved. The principle should be that it is his personal responsibility.

There might be some instance where he cannot get it, but those are local and not typical, and I am sure if some effort were made through a welfare agency that that could be obtained (hearings, p. 787).

On the other hand, Mr. Claud M. Andrews, head of the Florida Vocational Rehabilitation Agency, told the subcommittee that "the requirement that the individual submit his own medical evidence has continually posed difficult problems for the State agencies." He noted that vocational rehabilitation counselors are accustomed to obtaining the necessary medical information for their own clients, regardless of their financial ability to purchase examinations. Mr. Andrews concluded:

We understand that the Bureau's policy in regard to this matter was based on legal decisions which the Bureau had no authority to overrule or to change. We do feel that this is a subject which should be given further study by the Congress because the present system undoubtedly works a hardship upon persons who are not in position to obtain adequate medical information necessary to present their claims for benefits (hearings, p. 99).

The subcommittee, in connection with its survey of claimants, also made a survey of 78 doctors and 13 hospital administrators whose names appeared in the files of disability insurance applicants. These professional men were asked for their opinions as to whether the claimant or the Government should bear the cost of a medical examination and the preparation of the medical report form. The results of the survey were as follows:

Number of physicians favoring payments from.....	Patient	Government	Did not specify	No payment desired
For medical examination.....	53	22	3	-----
For medical report.....	36	24	3	15
Number of hospital administrators favoring payments from.....	Patient	Government	Did not specify	No payment desired
For medical examination.....	5	3	5	-----
For medical report.....	3	4	-----	0

Major reasons given by those respondents who favor payment by the patients were: (1) the burden should be placed on the applicants so as to discourage those who know they cannot qualify; (2) the patient should pay because he is the one receiving benefits; (3) the examination brings to light current maladies and the opportunity for treatment thereby directly benefits the patient; and (4) the patient, in choosing the doctor, has established a private relationship between the doctor and himself. The physicians and hospital officials favoring payment by the Government gave as their major reasons the fact that (1) disabled applicants cannot generally pay for the costs involved and (2) the Government should pay since it is seeking the information. A few respondents took the position that the Government should pay only if the patient is financially unable to do so.

The subcommittee believes that there is an honest difference of opinion and a lack of basic factual material on the question of whether there are needy claimants who are unable to get enough medical evidence in their file to meet the prima facie case requirements of "reasonable likelihood

** * * of disability." We request that the Department ascertain whether this is a real problem and, if it is, report to the subcommittee on the administrative cost and policy questions involved, together with recommendations as to what steps could be taken.*

ADMINISTRATIVE AND COST CONSIDERATIONS OF THE REMOVAL OF
AGE 50 REQUIREMENT FOR DISABILITY BENEFITS

During the course of the hearings the question of the desirability of removing the age 50 requirement, and the administrative ramifications which such a change would entail, came up time after time (e.g. hearings, pp. 70, 838-839, 858, 918, 922-924, 964, 975).

The evidence before the subcommittee was:

1. There is no administrative or other justification for continuation of this purely arbitrary distinction.
2. The distinction can be eliminated without an increase of the tax or impairment of the soundness of the trust fund, according to the Department of Health, Education, and Welfare.

As to administrative feasibility, Social Security Commissioner William L. Mitchell, told the subcommittee:

Probably the best way I can summarize my estimate of the state of disability operations is to say that there are no administrative obstacles in the way of improving the protection afforded by eliminating the present age restriction which now requires the worker to be 50 or over before he and his dependents can receive cash benefits on account of disability (hearings, p. 964).

As to cost, the Chief Actuary of the Social Security Administration, Robert J. Myers, testified that the age 50 requirement could be removed and the disability trust fund still would be in approximate actuarial balance (hearings, pp. 918, 922). This is due to the fact that the original estimate of the cost of the program which guided the Congress in setting the rate of tax was considerably higher than has been experienced in actuality, thereby leaving leeway for this proposed change.

○





THE EXTENSION OF OLD-AGE AND SURVIVORS INSURANCE
TO AGRICULTURAL AND DOMESTIC SERVICE WORKERS
AND TO THE SELF-EMPLOYED

Division of Tax Research, Treasury Department
November 1947

The Extension of Old-Age and Survivors Insurance
to Agricultural and Domestic Service Workers
and to the Self-Employed

The present social security system provides old-age and survivors insurance protection to employees in commercial and industrial enterprises. It leaves other categories of workers, including self-employed persons and agricultural and domestic service employees, without such protection. At the time of the adoption of the Social Security Act of 1935, the Congress postponed application of the program to these groups because of special administrative difficulties, pending the accumulation of administrative experience with a more limited program. In the meantime, the case for extending the old-age and survivors insurance program to these groups, among others, has been gaining increasingly wide recognition. This report explores alternative methods of achieving such extended coverage. It does not contain any specific recommendations, and is designed to facilitate discussion of the relevant issues by providing analytical and background material.

The study was prepared in the Treasury Department by representatives of the Bureau of Internal Revenue, the Office of Tax Legislative Counsel, and the Division of Tax Research. Valuable assistance and suggestions were received from the Bureau of Old-Age and Survivors Insurance of the Social Security Administration and the Staff of the Joint Committee on Internal Revenue Taxation, but the material contained herein does not necessarily represent the views of these organizations.

Division of Tax Research
U. S. Treasury Department

November 1947

The Extension of Old-Age and Survivors Insurance
to Agricultural and Domestic Service Workers
and to the Self-Employed

<u>Table of Contents</u>	<u>Page No.</u>
I. Introduction	1
II. Plans for the Coverage of Agricultural and Domestic Workers ..	6
A. Introduction	6
1. Domestic employment	8
2. Agricultural employment	9
B. Alternative plans of coverage	10
1. Plan I. - Present return system	11
2. Plan II. - Book-return system	13
3. Plan III. - Stamp system	16
C. Selected administrative issues	18
1. Identification of employer	18
2. Identification of employees in agriculture	19
3. Payments in kind	19
III. Plan for the Coverage of the Self-Employed	20
A. The tax base	21
1. Profits from trade or business	23
2. Interest, dividend and royalty income	23
3. Rents	23
4. Capital gains and annuities	24
5. Net operating losses	24
6. Partnership profits	25
7. Adjustment for taxable wages	25
B. Exemption from tax	25
C. Tax rate	27
D. Other considerations	28
1. Joint returns	28
2. Community property	28
3. Partnerships	29
4. Accounting periods and methods	29
5. Exclusion of nonresident citizens, aliens, etc.	30
6. Tax decisions to be binding for credit purposes	30
7. Reporting of self-employment tax	31
Appendix A: Detailed Comparative Description of Plans for Coverage of Agricultural and Domestic Employees	32
Appendix B: Items for Computation and Reporting of Self- Employment tax	44

The Extension of Old-Age and Survivors Insurance to Agricultural and Domestic Service Workers and to the Self-Employed

I. INTRODUCTION

The Social Security Act, approved on August 14, 1935, provided the United States for the first time with a general old-age insurance program and shifted this country from among the more backward to the more advanced countries in the field of social security. Its comprehensive character, notwithstanding, the 1935 Act provided old-age insurance coverage for only part of the country's population; it left large groups of people outside the program.

The principal groups excluded from the benefits of the old-age insurance program were agricultural workers, domestic service workers, self-employed persons, governmental employees, employees of educational, religious and charitable organizations, and persons employed in the railroad industry. In 1946 these categories included about thirty million people and represented approximately 40 percent of the country's paid employment.

The exclusion of the several groups from the program was prompted by different reasons. Railroad employees were covered by a separate system established by the Railroad Retirement Act of 1935. Governmental employees were excluded partly because some were covered under existing pension schemes and partly because of legal barriers to the imposition of a Federal tax on State and local governments in their capacity as employers. Less tangible reasons lay behind the exclusion of the employees of educational and other non-profit organizations.

Agricultural and domestic workers, and self-employed persons, now aggregating about 19 million, were not covered principally because the administrative problems in collecting taxes and obtaining proper wage reports were anticipated to be especially difficult. The concept of social security was new to this country and the introduction of a social insurance program represented a significant departure both for the Federal Government and the American people. In the initial stages of the program, it appeared desirable to restrict old-age insurance to those areas of employment where the prospects for successful operation were best. Moreover, it was anticipated that as administrative experience was accumulated, non-covered groups could be brought in at some future time without jeopardy to the entire system. It was made abundantly clear at all stages of the discussion that the exclusion of these groups from the initial program was a matter of expediency and in no way implied a permanent denial of the rights of these groups to old-age security on terms identical with those accorded to the covered groups.

In the case of the self-employed, the basis for exclusion was largely administrative in character and related to the problem of collecting taxes from self-employed persons with low incomes. The financial structure of the contributory old-age insurance system adopted in 1935 was built around employer and employee taxes on wages collected at source. It placed primary compliance responsibility on the employer and avoided the need for returns on the part of individual wage earners. This mechanism obviously was not applicable to the self-employed where employer and employee are one and the same person. The financing of social security benefits for the self-employed had to be built around some alternative structure involving self-reporting by covered persons. The mechanism which held most promise appeared to be an adaptation of the procedures used for income tax purposes. Since, however, the income tax of those days employed large personal exemptions and was a tax payable by a relatively small segment of the population, its adaptation for social security purposes would have required innovations which were then regarded to involve too much risk. The retention of income tax exemptions for old-age insurance purposes would, in effect, have entailed the exclusion of precisely those self-employed persons who were most in need of social security protection. The drastic reduction of exemptions or their complete elimination, on the other hand, involved questions of enforcement practicability which were then difficult to appraise.

Another problem which had to be resolved preparatory to the assessment of taxes against the self-employed related to the separation of that part of their income attributable to personal services from the balance due to capital investment. The tax which comprises a contribution for old-age security should apply only to the counterpart of wages -- to personal service income which stops when the worker retires and which establishes both the timing and the scale of his retirement benefits. Here again, income tax experience was relevant and indicated that this type of segregation was fraught with difficulties.

The principal consideration which influenced the decision to delay the coverage of agricultural and domestic workers under the original social security program related principally to the enforcement of social security taxes and adequate wage reports. A lesser problem was the valuation and taxation of income received in kind.

Since under the program eligibility for benefits and the size of those benefits were to depend upon earnings, it was essential to obtain a complete and accurate record of the earnings of each agricultural and domestic employee. This required employers to establish and maintain records of each wage payment made to their employees. While some employers were already keeping records of this type, it was believed that most farm operators and particularly housewives would find it burdensome to comply with the requirements, both because of their unfamiliarity with record-keeping and because of the rapid labor turn-over.

During the ten years of the old-age and survivors insurance system, the need for the expansion of its coverage has frequently received public recognition. In 1938 the Advisory Council on Social Security, established jointly by the Senate Finance Committee and the Social Security Board, recommended in its final report the coverage of most excluded occupations as promptly as possible. This was followed by similar recommendations made by the Social Security Board and the President, just prior to the commencement of the Congressional hearings which led to the 1939 amendments of the Social Security Act. That legislation made important revisions in the system but, except for several small groups, failed to broaden the coverage of the program.

Interest in expanded coverage continued. The Social Security Board recommended the enactment of legislation to this end in virtually every one of its annual reports. From time to time the President made similar recommendations to the Congress. In his 1946 Budget Message and again in 1947, President Truman called attention to the absence of social security protection for large segments of the population particularly in need of old-age security, and suggested legislation to eliminate the existing inequity.

During every session of Congress a number of bills were introduced providing for the extension of coverage either as a separate step or as part of comprehensive social security revision. Notable examples of recent proposals are those sponsored by Senator Wagner, Senator Murray and Representative Dingell for broad changes in the entire social security program, and by Senator Magnuson to provide a separate retirement program for all those not covered by existing Federal retirement legislation. The legislation pending in this session of Congress is illustrative of the varying approaches to the general problem. Senator Murray's bill (S. 1679) would make extensive revisions in the program including expanded coverage. Senator Magnuson has re-introduced his bill (S. 681). Representatives Curtis (H.R. 2046) and Bennett (H.R. 3457) propose coverage for the self-employed. Bills introduced by Senators Young (S. 508), Aiken and McFarland (S. 1743), and by Representatives Beall (H.R. 2022), Lynch (H.R. 2448), Curtis (H.R. 1892) among others would extend old-age and survivors insurance to other groups not now protected by the program.

The Ways and Means Committee undertook an investigation of various phases of the social security program, including expanded coverage, in 1945-46. Its staff of technical experts (appointed pursuant to H. Res. 204, 79th Congress, 1st Session), in reporting on this aspect of social security revision, concluded that it was feasible to extend coverage to the self-employed and to agricultural and domestic workers. Following the report of the Technical Staff, the Committee

conducted extensive hearings. Virtually every witness who addressed himself to the problem, including representatives of business, labor, farm organizations, Government, and religious, welfare and educational groups, favored extension of coverage to these categories of workers. In his testimony before the Committee, Commissioner Altmeyer of the Social Security Administration emphasized the need for extending the coverage of old-age and survivors insurance, and presented in some detail a plan for covering self-employed persons. Agricultural and domestic workers, he indicated, might be covered either by a stamp plan or by a system of employer reports.

The growth of interest in the extension of social security coverage during the past ten years was accompanied by the accumulation of administrative experience which resolved some of the problems envisaged at the time the program was first developed. The wartime reduction of personal exemptions under the individual income tax to \$500 per taxpayer provided experience with tax returns from low income recipients. In the case of most farm operators and many employers of domestic service workers, it established the need for the maintenance of operating records. These developments have direct application to the problem encountered in the extension of old-age insurance coverage. Other developments, such as the farm aid programs and rationing, have contributed to making the population record conscious. Administrative authorities have acquired more than ten years of experience in enforcing social security taxes under diverse circumstances. At the same time, the generally high level of economic activity, including employment, reduced the rate of labor turn-over in domestic employment and the burdensomeness of employment taxes. These developments have improved the case for the extension of old-age insurance coverage.

The present report, which draws heavily on the Treasury Department's experience with the administration of the tax aspects of the social security system, examines the problems of extended coverage and discusses alternative plans for bringing the self-employed and the agricultural and domestic workers into the system. In examining the available alternatives, it appeared desirable to confine detailed consideration to those plans which were consistent with the principal characteristics of the existing social security system. Consequently, some plans which under other circumstances would deserve careful evaluation were not considered.

The present social security program is financed by a payroll tax imposed at a rate of one percent each on employees and employers. The receipts from this tax have been sufficient to pay the current cost of benefits and to build up a substantial reserve, and are expected to continue to do so for some years to come, notwithstanding anticipated increases in aggregate benefit payments. It is estimated on the basis

of a relatively optimistic set of consistent assumptions regarding the long-term operations of the system (high wages, low retirement rates, etc.), that the level cost of the system is about 3 percent of payrolls. Under a less optimistic set of assumptions, the level cost of the system is estimated at approximately 7 percent of payrolls. Nevertheless a combined tax rate of only 2 percent has been continuously in effect since the origin of the program, with the result that the system has been operating at an actuarial deficit, even if the most optimistic set of economic and demographic assumptions underlying the calculations made thus far should materialize. In the absence of an adequate increase in the payroll tax, the deficit will presumably be made up from the Government's general fund when the cash benefit obligations of the system warrant it.

This prospective dependence of the system upon some financing from the general fund prescribes in some measure the plans available for the coverage of hitherto uncovered groups. It precludes, for instance, recourse to a plan for voluntary coverage. Under such a plan, those who could best afford to come into the system would do so, while some of those whose need for protection is greatest would not acquire social security coverage. As a result the general fund would tend to subsidize social insurance protection for the benefit of a select group of individuals who need it less than some of those not covered. To safeguard the principle that the Government's general funds serve the purposes of all the population on a fair and equitable basis, it is necessary to limit the choice of plans for the extension of coverage to those which extend protection on the basis of reasonably fair classifications. Voluntary coverage, dependent as it is on the financial position of the insured, would not meet this test. It should also be noted that there are other objections to a voluntary system. For example, it would tend to involve an adverse selection of risk and would thus impose added financial burdens on those who are compulsorily covered by the program.

A further illustration of how the characteristics of the present system restrict the alternative approaches to broader coverage may be cited. From some points of view, there is much to be said for a plan of direct reporting by agricultural and domestic workers themselves by means of an annual return of wages and payment of taxes, similar to that required under the income tax and under a plan discussed below for self-employed persons. Such a plan would preclude the collection of a tax from the employers of such workers, and would involve corresponding discrimination between employment in commerce and manufacturing and employment in agriculture and domestic service. Moreover, it is likely that such a plan would have to exclude a substantial number of employees. It was for these reasons ruled out of consideration.

The plans developed below accord closely with the requirements of the existing social security program. They deal only with the tax collection aspects of the problem. No attempt has been made to develop specific benefit provisions appropriate to the proposed tax plans. Since, however, the plans have been molded as nearly as possible to the present benefit structure and its qualifying provisions, the development of parallel benefit provisions should not present special difficulties.

It should be noted, also, that this analysis of alternative approaches to extending coverage involves of necessity a large element of judgment. The advantages claimed for one approach as against another, are to a large extent based upon tax collection experience under different circumstances than those which will prevail when coverage is extended. We have had, for example, extensive experience with the taxation of low incomes. Nevertheless, if in conjunction with a tax on the self-employed with low incomes, a program of benefits directly related to that tax were introduced, past experience would not necessarily provide a reliable gauge of the compliance to be expected. The payment of benefits introduces a new factor which may produce more favorable results than those obtained when no quid pro quo was associated with payment of the tax.

On the basis of the studies that have been made, it appears evident that administrative considerations no longer constitute a barrier to expanded coverage. The administrative problems are difficult, as was the case when the existing program was initiated, but given a moderate period of experience and adequate appropriations for the administration of the enlarged area of coverage, they can be resolved. Moreover, tax collection features and costs are but some of the factors to be considered. Other elements such as equity among different groups and the possible reduction of public assistance costs which are borne out of general revenues, as well as public attitudes toward social security and other social considerations, also enter into the evaluation process. Whether the old-age and survivors insurance program is to afford protection to segments of the population now deprived of its benefits, is a question of public policy to be determined in the light of these considerations.

II. PLANS FOR THE COVERAGE OF AGRICULTURAL AND DOMESTIC WORKERS

A. Introduction

The basic problem inherent in the extension of old-age and survivors insurance coverage to agricultural and domestic service workers is associated with the economic characteristics of these groups. The small number of employees per employer, the comparatively low level of wages, the relative frequency of seasonal work, the geographic dispersion of employers, the lack of employee organizations and the inadequacy of employer records make for costly administration. Although the feasibility of coverage in this area cannot be assessed primarily on the basis of a comparison of the ratio of cost of administration to

tax collections with that under either the present social security program or the Federal tax system as a whole, the consideration is relevant, and together with the cost of maintaining records required for the determination of benefits, will have an important bearing upon the evaluation of the alternative plans described below.

The average number of workers per employer under present coverage is high compared with that in agriculture and household employment, approximately 20 employees in commerce and industry and only about 1.5 in agriculture and even less in domestic service. To be sure, these averages exaggerate the differences between these broad groups. It is important to note that despite the high average per employer under present coverage, fully one-half the employers have three or less employees and more than one-fourth have only one employee. Likewise, the low average in agriculture tends to obscure a high degree of concentration. Thus, about 600,000 farm operators in 1945 (about one-fourth of the agricultural employers) employed 80 percent of the hired farm labor used in that year. While there are large areas within agricultural and domestic employment in which the costs of administration would compare with those now involved in collecting contributions from small industrial employers, the average cost for the group as a whole would be higher. A low average number of employees per employer means a relatively small amount of tax per return and relatively high administrative and enforcement costs in relation to collections. ^{1/} Under existing coverage, collection costs amounted to 71 cents per \$100 of revenue for fiscal year 1946, and with broader coverage this ratio would undoubtedly be increased (assuming no change in tax rates).

Another consideration, relevant in the case of domestic employment, is that wages paid to domestic workers in a private home are not allowable as a deductible expense in computing net income for income tax purposes and hence the income tax cannot act as a deterrent to under-reporting of social security taxes in this area. Still another consideration is the circumstance that the proportion of employees who are seasonal or part-time workers and shift from one employer to another during the course of their annual employment is much higher in agriculture and domestic service than in commerce and industry.

^{1/} It should be noted, however, that the unit cost of covering other non-covered groups, such as employees of non-profit institutions and Government employees, may be expected to be less than for agricultural and household employment. Consequently, with a program of complete coverage, costs in relation to collections may not be significantly greater than at present.

1. Domestic employment

Prior to the war about 2.6 million persons were engaged in domestic service at any one time. 1/ This may be assumed to represent roughly the normal force in this occupation, although in periods of full employment it may be considerably smaller because of other more attractive employment opportunities. The great majority of domestic workers are women. 2/ There were about 1,650,000 employed domestic workers in July 1946, of whom 100,000 were men. About one-fourth of the women were married and living with their husbands, according to the last population census. About 27 percent were 45 years old or over, 3/ and more than half were of the white race. In the country as a whole, almost one-third of the domestic workers lived in rural areas.

An estimated one-third of the domestic workers were "living-in," according to sample statistics from the 1940 census. In all, one-half of the domestic workers had jobs the year round, and may be considered regular full-time employees. Another fourth may also have been regular employees on a part-time basis, but their number is indeterminate. Data on the number of employers of domestic labor are not available, but as a working basis it is assumed that on the average there are three employers for every two domestic workers.

Earnings were very low for most domestic workers before the war. The annual median cash earnings of full-time workers amounted to less than \$400. The extent to which these earnings were augmented by income-in-kind is unknown. It is likely that in addition to those "living-in," many other domestic workers received some income in kind. There is some scattered evidence that cash wages of full-time domestic workers have more than doubled since the beginning of the war. Taking into account the volume of part-time employment, the average cash wage of domestic workers may still be only \$700 or \$800 annually.

A pre-war survey of white domestic workers in Chicago revealed that approximately one-sixth of the workers had been employed in covered industry sometime since the enactment of the program. It is likely, however, that a much larger proportion of such workers acquired some social security coverage during the war which, in the absence of expanded coverage, will be lost.

1/ If chauffeurs, gardeners and practical nurses are excluded, the total is about 2.3 million persons. The proportions and percentage figures in this section are based upon the smaller total.

2/ In 1940, only 150,000 men were in this occupational group.

3/ Among female clerical and sales workers only 13.7 percent were in this age group.

2. Agricultural employment

During 1946, about 3.5 million persons worked as hired agricultural laborers. The number of workers grew from a more or less permanent force of about 1 million employed at the beginning of the year to about 3 million in the fall harvest period. Thirty-three percent of these workers reported that farm wage work was their major activity and the only kind of work they had done in 1946. This 33 percent of the workers, which included most of the regular hired hands, accounted for 60 percent of the total time worked at hired farm work during the year. In contrast, the school youths, the housewives, and the miscellaneous group--that together made up 27 percent of all the workers - accounted for only 10 percent of the days of hired farm labor. They were used mainly in seasonal rush jobs. An additional 19 percent (534,000) reported that they operated a farm during 1946 and for most of these, hired farm work was secondary to the operation of their own farms. This group accounts for 12 percent of the hired farm work done during the year. Twenty-six percent of the farm wage workers, however, also had earnings from nonfarm work. This group which represents the overlap of the farm and nonfarm labor market accounted for 18 percent of the hired farm work done during the year.

Geographically, the southern States account for the largest proportion of hired farm workers. Depending upon the season, this area accounts for between 40 and 50 percent of the workers. The western and north central States each account for about one-fifth and the northeastern States for the remainder.

About three-fourths of the hired farm workers in 1945 were men, more than half of whom were heads of households. Among the women only about 10 percent were heads of households. Many of the farm workers are young people, about 20 percent of the men and 30 percent of the women being less than 20 years old. However, almost one-third of the men may be 45 years of age or over.

The earnings of agricultural workers vary geographically and according to whether they are regular or seasonal workers. The lowest wages are earned in the South and the highest in the West. In September 1945, average daily earnings ranged from \$2.90 in the southern to \$6.80 in the western States. The farm wage bill for 1943 divided by the average monthly number of farm workers indicated an average wage of approximately \$800. In 1939, the median cash income of farm workers was approximately \$260.

Another factor entering into the earnings of agricultural workers is the wages-in-kind which they receive. The most important perquisite item is housing. In September 1945, about 36 percent of the farm workers received lodging or were allowed the use of a house, including 14 percent who received both housing and meals. Only 3 percent received meals but no housing. Although perquisite items are furnished to regular workers more frequently than to seasonal workers, over one-fourth of the latter received meals or housing or both. Other types of perquisites are also given to agricultural workers, such as the use of a garden plot, equipment, animals, and produce. In the aggregate, the value of perquisites is estimated by the Department of Agriculture to have been about \$350 million in 1945. The values of perquisites given to individual workers are not available, but related data indicate that the daily value of meals ranged from 40 cents in South Carolina and Louisiana to \$2 in the State of Washington.

Although there were nearly 6 million farms in 1945, only about 2.8 million used hired workers. Probably less than one-half million used hired labor throughout the year. The others employed workers for varying periods of time, but in most cases the total amount of labor hired was small. During 1945 there were an estimated 1.7 million farms each using less than 75 man-days of hired labor. On the average, these farms used only 20.9 man-days, and in the aggregate they accounted for only 7.6 percent of the total number of hired man-days during the year. The annual cash wage bill on these farms averaged less than \$100.

The remaining 1.1 million farms hired considerably more labor during 1945. About one-half million farms hired up to 250 man-days of labor. On the average, these farms used 119 man-days of labor and had an annual cash wage bill of about \$550. Another 600,000 farms, using 80 percent of the hired manpower employed during the year, makes up the 2.8 million farms. These farms used at least one-man year of labor each and had average annual wage bills in excess of \$1,000. The total cash wage bill for hired farm labor in 1945 is estimated at \$1.9 billion.

B. Alternative plans of coverage

Several types of mechanism are available for the collection of taxes and wage data with respect to agricultural and domestic employment, ranging from a single extension of that now in use to one which combines with that system entirely new machinery. The discussion below suggests that a selection from among alternative plans will need to be made on the basis of several criteria, and in the light of a delicate balancing of the technical administrative considerations on the one hand and the desired coverage on the other.

Of the alternative plans which have been considered for extending coverage to agricultural and domestic workers within the framework of the existing system, the three most promising are: (1) the present return system by itself, (2) the present return system supplemented by employee wage books (book return system), and (3) the present return system combined with a stamp system. Each of these would provide the Federal Government with reports of wages paid to domestic and agricultural employees and enable the collection of the two employment taxes - one from the employer and one from the employee. All three plans have one principal feature in common. They provide for the use of the present employer reporting system over a substantial segment of agricultural and domestic employment, within the area where the characteristics of employment are similar to those prevailing in commerce and industry. It is only with respect to the balance of agricultural and domestic employment that the plans differ. They differ also as to their enforceability in irregular and part-time employment with corresponding implications as to the coverage they can provide. The plans differ also as to the manner in which the data would be reported, the Government agency charged with the enforcement, and the effort entailed on the part of the Government, the employer and the employee. A detailed tabular description of these three plans for the coverage of agricultural and domestic workers will be found in Appendix A.

1. Plan I. - Present return system

Plan I consists of the extension to agricultural and domestic workers of the system of quarterly returns now employed under the Federal Insurance Contributions Act.

Under this system every employer and employee is assigned an identification number by the Social Security Administration. Each calendar quarter the employer files with the collector of internal revenue a return (Form SS-1a) which reports the employer's name and identifying number, each employee's account number, name, and quarterly earnings, and the computation of tax liability. The employer withholds the employee's tax from his wage payment, keeps records of both wages and tax, and each quarter remits both the employees' and employers' tax with his return. Periodically or on termination of employment the employer furnishes each employee a statement showing his wages and employees' tax.

The collector detaches the schedule of employee wage information from the return and transmits it to the Social Security Administration where the amount of each employee's wages is posted to his social security account.

The principal consideration in favor of Plan I is its utilization of routines and administrative procedures which have been in use for more than ten years. A number of employers of domestic and agricultural labor are already subject to the requirements of the existing system by reason of their concurrent employment of industrial or commercial workers. The inclusion of their agricultural and domestic employees' wages on their quarterly return should not constitute any serious burden. This plan depends primarily on employer compliance, although it provides some scope for employee participation in enforcement. 1/

Considerable resistance and inertia may be expected at least initially, from employers who are unaccustomed to record-keeping. Unlike agricultural employment, the wages paid for domestic service are not deductible for income tax purposes. Hence there is no incentive, other than for budgeting, for a housewife to keep a record of such wages. The same may be said of the small farm employer who does not file income tax returns. Such resistance might be offset in a number of cases where a close relationship has developed between employer and employee. A respect for law will overcome resistance in many other cases. An educational program encouraging employees to remind their employers to withhold their employee contributions, to insist on their annual or termination receipts for withheld contributions, and to inquire periodically regarding their wage credits at the Social Security Administration would also lend considerable aid to enforcement. An offsetting consideration is the probable unwillingness of some employees to jeopardize their jobs by reporting the delinquency of their employers or to disclose their own income tax delinquencies.

With a view to avoiding troublesome administrative problems associated with the coverage of employees hired by occasional employers, this plan could be drafted so as to exclude the non-business connected services of children under the age of 16, and the services of employees when performed for the employer on less than eleven days in any two consecutive calendar

1/ The Social Security Administration currently issues over 400,000 wage statements annually in response to requests from employees, who have authority under the present system to ask for such statements, to enable them to check on the accuracy of their Social Security wage records.

months, provided that the employer has not paid taxable "wages" to any other employee during the calendar quarter. ^{1/} Such a limitation would restrict the tax and reporting burdens to the more established employers who generally have a long-term relationship with their employees and may be interested in the old-age security of such employees. The ratio of employees to employers under such a plan would be relatively high, and the amount of taxes due from individual employers would seldom be less than, and generally in excess of, \$1 per calendar quarter. Other methods of defining casual labor in these fields might be devised, but experience alone can provide the basis for determining how much further in the direction of complete coverage the present system can be pushed.

2. Plan II. - Book-return system

Under Plan II all employers who keep permanent records of their own (which would include all of the larger agricultural employers) would, upon application to the Commissioner, be permitted, and thereafter required, to follow the same procedures as contemplated under Plan I (quarterly tax and information returns on Form SS-1a). All other employers would be required to file quarterly tax returns but would be under no obligation to keep permanent wage records or to fill out a quarterly wage schedule reflecting the name, social security number and quarterly wages of each employee, as under Plan I.

Each employee would make a written application each year to the Social Security Administration for his annual wage book. The book would consist of a number of sheets, each consisting of a stub and a detachable slip, separated by a vertical perforation. The Social Security Administration would enter the employee's account number (and his name, if practicable) on each sheet of the book. At the time of the first wage payment, the employer would enter the amount of wages, and the date of payment both on the stub and the slip and would initial the stub. The employer would retain the slip and other payments in that quarter would be entered on the same stub and slip. Payments in subsequent quarters would be entered on successive pages in the book. The book would contain instructions and an application blank for a new book. A sample sheet will be found on page 35.

^{1/} The 11-day yardstick would exclude from coverage the once-a-week domestic worker who may have several employers, each owing an insignificant amount of tax. It has been the principal yardstick under the Federal Insurance Contributions Act for the exclusion of casuals who perform services outside the course of an employer's trade or business. It should be noted that under such a rule, as under existing law, some occasional employers may not know whether to withhold tax until after an employee's services have been terminated.

At the end of each quarter, the employer would file a tax return identical with the summary (upper) portion of the present Form SS-1a, to which he would attach all the slips taken from the books of his employees. Large employers, and others who keep good records, upon proper application to the Commissioner, would be permitted to dispense with this procedure and would report the wages to their employees in the same manner as under the present reporting system. Such employers, however, would have to advise their employees that the Commissioner of Internal Revenue has specifically waived the requirement of wage entries in employees' books.

While no final determination can be made at this time as to the extent of coverage which might be obtainable under Plan II, the plan as presented contemplates the exclusion of (1) nonbusiness connected services of children under the age of 16, and (2) the services of any employee who works for the particular employer less than three days in any two consecutive calendar months provided the particular employer employed no other covered workers during the calendar quarter. 1/

The main feature of this plan lies in the fact that it would enable many agricultural and domestic workers (particularly casual workers) to bring their interest in their own security to bear much more effectively than under Plan I on employer compliance with the program. Employers using the book-return system would continue to be responsible for filing reports and withholding and paying taxes as under Plan I, but their employees would have a greater opportunity to check employer compliance by insisting upon proper entries being made in their wage books.

The book-return plan, given adequate employee cooperation, would facilitate the task of most employers because the detachable wage slips in the employees' books would enable employers to report the names, account numbers and wages of their employees with the quarterly tax return without establishing a separate recording system for that purpose. The preparation of their quarterly reports would be partly accomplished by the detachment of the wage slips and would not require the transcription of wage data from office records to special reporting forms. In addition, this mechanism would minimize the likelihood of errors in reporting employees' names or account numbers, since employers would not be required to make such entries on wage reports. An offsetting consideration from the viewpoint of employers is their being required to handle wage books and to make entries into them under difficult conditions,

1/ The 3-day exclusion rule is designed to eliminate the tax and reporting burden of the employer in those cases where employment is casual and of brief duration, and where both the tax and wage credit are likely to be insignificant.

as in the case of payments to farm labor in the field. In addition, some employers who now keep complete records of wage payments may suffer some inconvenience in having to make entries in the wage books. 1/

In affording employees an opportunity to supervise the compliance of employers with the program affecting their own old-age security, this plan would enable employees to safeguard their interest in the program even during the period when the payment of benefits appears to be remote.

The advantage of Plan II from the point of view of the Government, apart from coverage, is the aid to enforcement resulting from employee participation in the system and from the mechanical aids provided the employer. These gains would be secured at the expense of some departure from present procedure. While the basic elements of employer withholding and reporting of taxes and wages would be retained, the procedures now followed by employers, employees and the Social Security Administration would be substantially changed. The wage slips might be especially troublesome to process, as was the case when the social security program was first instituted and slips were used, but the number of such slips would be far less and the processing steps would be far simpler than under the early system. The wage book mechanism would be costly and the extension of coverage to include workers with small earnings might require many returns showing tax liability less than the expense of processing the returns. The value of the enforcement aids inherent in the employees' participation in the program would be reduced to the extent that there is employee resistance to presenting these books to employers every pay day, to filing timely applications for new wage books, and to returning their old books to the Social Security Administration on schedule. The unwillingness of employees to press their employers to report wage payments which would reveal income tax delinquency, and the risk of jeopardizing their own jobs by reporting delinquent employers, would contribute to the reluctance of employees to exploit the advantages inherent in the proposed mechanism. Moreover, since the employer would not be required to retain a copy of the quarterly wage record of each employee (although he would retain a copy of his quarterly tax return showing the total wages during the period), field investigation would in some cases be hampered.

1/ Since the exclusion under the plan might require an employer to wait for three days before determining whether his wage payments are taxable, cases may arise, as they do under present law in connection with non-business casual workers, where an employer may not know whether to withhold tax until an employee's services have been terminated.

3. Plan III. - Stamp system

Plan III involves the payment of social security tax through a stamp system. But as in the case of Plan II, it contemplates the use of the present reporting system in that area of agricultural and domestic employment where it is practicable from the viewpoint of the employer and the administrative authorities. Prior to 1940 operators of packing and processing plants were covered by the present reporting system and in many cases make similar reports at present to State agencies. With the coverage of agricultural employment, these as well as some other categories of employers could readily operate with quarterly reports. It would be possible to develop a definition of the types of employers who should report wage payments in the same way as employers in commerce and industry. In addition, other employers would upon application to the Commissioner be permitted to use the present reporting system. The distinction between employers who would be required to use the present reporting system and those who would be required to use the stamp plan would need to be left to administrative determination on the basis of changing experience. The rules governing the choice of reporting methods would have to be framed in specific terms so that employers and their employees could readily determine which method applies.

In those areas of agricultural and domestic employment which are not covered by the present system, the stamp plan would apply. The social security tax would be paid through the purchase of stamps by the employer and his affixing them to the employee's stamp book. The stamps accumulated in this book would constitute the employee's working record during the period the book is valid. When paying wages, the employer would withhold the employee's tax and affix and cancel stamps in an amount equivalent to the sum of the employer's and the employee's tax.

Each agricultural and domestic employee would obtain a social security account number and a stamp book from the Social Security Administration. The stamp books, valid for six months, would be presented to the employer for affixing the appropriate stamps at the time wages are paid. Each stamp book would contain a detachable form to be mailed by the employees to the Social Security Administration shortly before the end of the 6-month period, applying for new books and listing their current addresses. It would also contain space on which an employee would enter the name and address of any employer who failed to affix stamps, together with the amount and date of wage payments. Upon receipt of the employee's application, the Social Security Administration would issue a new book. At the close of each 6-month period, the employee would send his old book to the Social Security Administration for posting and other processing.

On presentation of completed application forms, employers would purchase social security stamps, available in suitable denominations, from post offices, rural mail carriers, and collectors of internal revenue. In the case of employees who fail to present their stamp books, employers would be required to report on prescribed forms the employees' account numbers, names and wages, and to affix the necessary stamps to that form.

The stamp plan would provide potentially complete coverage for all agricultural and domestic workers. It would abandon the periodic employer-Government relationship inherent in the present reporting system, and would rely for enforcement principally on the willingness of the employer to comply and on the self-interest of the employee in policing the system.

Under the plan, employers would not have to keep any special wage records, or make out any tax returns other than a requisition form in purchasing stamps. The stamps would also serve as the employee's receipt. However, employers would find it inconvenient to purchase and keep on hand an adequate supply of stamps, to process stamps by affixing and cancelling them (sometimes under field conditions), and to handle soiled and mutilated books. Employers would also find it difficult to make wage reports where the employee failed to present his book for the insertion of stamps.

Employees would be afforded an opportunity to take a direct part in safeguarding their old-age security interests, but by the same token, employees would find it relatively easy to alter their wage records by the fraudulent sale or purchase of stamps, thereby either sacrificing their old-age security interest for immediate gains, or obtaining higher old-age benefits than is planned. It should be noted, however, that in order to increase their benefits to any great extent, younger employees would have to alter their wage record over a long period of time. As an additional safeguard, the employee would be required to sign, under penalties of perjury, a "Worker's Declaration" upon submission of his book to the effect that the stamps in the book reflect bona fide employment. The loss of stamp books would penalize employees, unless they could present a satisfactory reconstruction of their earnings record.

From the viewpoint of the Government, this plan offers an opportunity to place the tax collections on a pay-as-you-go basis through the purchase of stamps in amounts related to current operations. At the same time, it would minimize the possibility of erroneous reporting of employees' names and account numbers. These gains would be secured, however, by a tax collection and wage reporting system distinctly

different from the present system, which would need to be administered along side of the present system and would not allow for effective auditing and spot checking. However, it would be possible to reduce non-reporting or erroneous reporting of wages by means of the employer's purchase application forms, by ascertaining whether he is purchasing stamps in amounts corresponding to his payroll. An effective public relations program designed to inform employers and employees of the objectives of the extended program would also have salutary effects.

This plan would place heavy reliance for enforcement upon employees, whose interest in eventual benefits may be insufficient to overcome their resistance to carrying the stamp books, presenting them to employers at the proper time and providing the Social Security Administration with the necessary information to obtain new books. Moreover, employees may prefer to forego eventual old-age insurance benefits rather than disclose information to the Government which would reveal income tax delinquency, or jeopardize their jobs by reporting delinquent employers and reduce the contents of their pay envelopes by the amount of the employee tax. This may be offset by the value placed by employees on insurance against current risks and the protection thus given to their dependents.

Finally, use of the stamp plan would impair the effectiveness of the "work clause", 1/ since an employee desiring to conceal current earnings in excess of the allowable maximum, in order to qualify for benefits, could prevent the posting of wages to his individual account by failing to submit his stamp book to the Social Security Administration. This difficulty would be mitigated to the extent that the Social Security Administration found it practicable to check on those individuals in benefit status, who have failed to apply for stamp books or having received stamp books failed to return them.

C. Selected administrative issues

1. Identification of employer

With respect to the services of employees performed for husband and wife who are living together, some difficulty might be encountered in determining the identity of the employer.

1/ The "work clause" disqualifies for benefit payments any annuitant who during a given month earns more than \$14.99 in covered employment. Under the existing system, the Social Security Administration receives regular reports of covered employment which permits enforcement of the "work clause".

While in the ordinary case there would be no question as to the liability of the husband as the principal employer, there might be a number of border-line cases where the service inured solely to the wife's benefit, was outside the category of necessities, and was paid for by the wife out of her own funds. In such cases, it would not be proper to prescribe that the husband is liable as employer.

The possibility of defining "employer" arbitrarily to include both spouses jointly in all of such cases is likewise impractical because it would create a new employing entity separate and distinct from either spouse and would thereby prevent one spouse, who has other employees of his own, from including his domestic or farm employees on the same return.

In the light of these difficulties, it appears that until adequate experience is acquired on this matter the problem might best be solved by way of a ruling (rather than a statute) raising a rebuttable presumption that the husband (living with his wife) is the employer in all cases of agricultural or domestic service performed for either, or both, of them.

2. Identification of employees in agriculture

The eleven-year old problem of determining who are employees would be greatly intensified in the field of agricultural labor which abounds in workers, such as sharecroppers, labor contractors, and heads of family groups, whose classification falls into the twilight zone between the concepts of "employee" and "independent contractor."

Without laboring the characteristics of such workers concerning whom there are relatively little available data, it appears advisable not to attempt at this time to provide any special statutory definition of the term "employee" as applied solely to the field of agriculture. Until more experience is acquired with respect to the coverage of such workers, this problem might best be solved by way of rulings or regulatory presumptions.

3. Payments in kind

A substantial number of domestic and agricultural workers receive part of their remuneration by way of meals, lodging and other perquisites. Such income in kind ought to be included in "wages" for purposes of tax as well as credits under OASI to the same extent that meals, lodging and other perquisites are considered under existing coverage. In other words, no arbitrary table or series of tables should be established either in the Code or Regulations, and values should be determined as at present on the basis of a rebuttable presumption that the employer may use tables of reasonable values established by State agencies for each locality. If State tables are found inadequate, an acceptable alternative would be the use of tables of presumptive values approved by the Bureau of Internal Revenue and the Social Security Administration.

III. PLAN FOR THE COVERAGE OF THE SELF-EMPLOYED

The plan for the inclusion of the self-employed in the old-age insurance program involves a departure from the mechanism now employed in that program, under which employers report the wage records of their employees and make quarterly payments covering both their own tax and the taxes of their employees which are withheld from wages. Because of the inapplicability of the collection-at-source mechanism, the proposed plan relies on the introduction of a self-reporting system. Self-employed persons would be required to file social security tax returns covering their self-employment income and to pay the tax directly to the collectors of internal revenue, very much as taxpayers now file income tax returns. The plan would associate the collection of the social security tax with the income tax.

The degree of coverage under a plan of this sort is a function of the size of the exemption in relation to the levels of income. The higher the exemption, the less the coverage, and vice versa. The determination of the size of the exemption is a policy decision, which should be made in the light of the implications of an exemption of any given size on the cost and other aspects of administration on the one hand, and the degree of coverage on the other. The extent to which complete coverage can be approached is limited only by the Government's readiness to undertake the administrative burdens involved. In the plan here described, the point of departure is the minimum exemption now allowed under the Federal income tax.

The self-employed constitute a heterogeneous group of about 11 million persons. The largest single occupational class is composed of farm operators, representing about half of the total number of self-employed persons. The remainder, the non-agricultural self-employed, are scattered through many industries. Over one-third were concentrated in retail trade, according to the 1940 Census. More than a fifth were in service industries. The professions and the construction industry each accounted for about one-tenth of the urban self-employed.

Among the urban self-employed it is estimated that before the war about 94 percent had a gross income of \$500 or more, and about three-fourths had a net income of at least \$500. The level of income among the 5.5 million rural self-employed was substantially lower. Over half of the self-employed farm operators, for example, had an output, including products raised for home use, valued at less than \$750 in 1939. Many of these farm operators were not entirely dependent on their farm operations. A large proportion worked 100 days or more off the farm; many were over age 65 and probably represented retired farm operators. About 3.7 million persons were wholly or principally dependent on their farm operations. Of these about 1.2 million were in the "poverty" group, each with a gross farm output valued at less than \$750. There were only about 50,000 farm operators with a product valued at \$10,000 or more.

About two-thirds of the farm operators in 1940 were either part or full owners of their farms. Among those operating as tenants (excluding sharecroppers) nearly half were on a share basis. Independent farm operators were almost entirely men, with a median age of 49.3 years. Over four-fifths of the farm operators were married.

The plan for the coverage of the self-employed described below calls for the imposition of a tax on self-employed individuals measured by selected items of income reported for income tax purposes. It provides for the segregation of that part of total income which is most nearly comparable to wage income and analogous to earned income. Individuals affected, limited to those whose self-employment income for the taxable year exceeds the exemption, would file an annual self-employment tax return and pay a self-employment tax at the same time as they filed their income tax return and paid their income tax. The maximum amount of taxable self-employment income for the year would be \$3,000, less such amounts of wages as have been subject to social security tax withholding by the employer. ^{1/} The base for the proposed self-employment tax would be derived from items of income reported on the income tax return, and this would facilitate appreciably tax administration and taxpayer compliance. Approximation of a tax base as nearly comparable to that employed for wage earners would be achieved by eliminating from the base insofar as practicable those items of income which are clearly unearned, with due consideration for administrative practicability. The Bureau of Internal Revenue would collect the tax and transmit the relevant income information to the Social Security Administration for posting and crediting to the individual's old-age insurance account.

A. The tax base

The key to the definition of the tax base for the purpose of an old-age insurance tax imposed on the self-employed is the isolation of earned income from total self-employment income. This is essential to place the self-employed on a par with recipients of wages. More important, it is essential to the creation of a system of insurance sensitive to the timing of retirement and the amount of the income loss resulting from retirement.

^{1/} Throughout this section reference is made to taxable self-employment income of \$3,000, to accord with the corresponding provision under present law. This study had not considered the case for raising the amount of taxable wages and the reference to \$3,000 is not intended to prejudge that issue.

The existing social security program is designed to compensate individuals and their families for the loss of wage income incident to death or retirement. This requires the determination of income from personal services. In the case of wage earners, the determination is generally simple; it corresponds to the contents of the pay envelope. In the case of self-employed persons, however, it presents difficulties because their income is generally a mixture of wages for personal service and of return on invested capital. For purposes of the old-age insurance tax, it is necessary to identify as nearly as possible these two categories of income, to segregate the income attributable to personal services, which presumably stops at death or retirement. In the absence of such a segregation, those self-employed persons whose income includes an element of return from capital which continues after their retirement could either be required to continue to pay contributions and fail to qualify for benefits after they retired or a test of retirement independent of income could be prescribed.

Inasmuch as tax practice has not yet developed an adequate procedure for isolating earned income from investment income applicable to the self-employed, the segregation for old-age insurance purposes must be made arbitrarily. Such segregation can be made by the inclusion and exclusion of broad categories of income received by individuals from particular sources and already reported for income tax purposes. This procedure, described below, provides a reasonably satisfactory working basis for purposes of the old-age insurance tax.

In connection with the coverage of the self-employed, special consideration may have to be given to the scope and application of the work clause. Retirement among the self-employed is a vague concept. Many self-employed persons never actually retire; they work a diminishing number of hours or handle a diminishing number of cases. The practice among lawyers to accept an occasional special case at an age when industrial employment would have prescribed retirement, or the tendency of shopkeepers to continue making token appearances on the premises after they have yielded management to their successors, is illustrative. A related consideration is the practice among wage earners to enter self-employment after being retired as employees. This suggests that a modification of the present work clause is necessary to avoid barring certain self-employed persons from qualifying for benefits even if they were accorded coverage. One such modification might be elimination of the work clause for all persons after they reach age 70.

1. Profits from trade or business

"Profits from trade or business" are now reported as a separate item on the income tax return. Such profits are generally derived in connection with the application of personal services to an enterprise. They are normally "work-connected" and, therefore, should be included in the tax base for the self-employment tax. In the case of those filing income tax returns, this item may be transferred from the income tax return for purposes of the self-employment tax return. The determination of what constitutes a trade or business for purposes of the self-employment tax will raise difficulties in some cases which do not need to be resolved for purposes of the income tax and, as many taxation problems, will have to be settled by administrative decision.

2. Interest, dividend and royalty income

Interest and dividends would be excluded from the proposed tax base because normally they constitute investment income. However, in many cases such items of income are "work-connected" and analogous to the earnings of an ordinary business enterprise, as for example, in the case of small loan operators, security dealers, and pawnbrokers. Moreover, virtually any enterprise may receive interest on its accounts receivable or on notes which it holds. To the extent, therefore, that interest or dividends are trade or business income, provision would be made for including such income in the self-employment tax base.

What has been said of interest and dividend income applies equally to royalty income, and to the extent that such income is derived from a trade or business, it would be included in the self-employment tax base.

The proposed differentiation of interest, dividend and royalty income as between business receipts and personal investment income may be significant in only a relatively few cases. Only when an individual's self-employment income from other sources together with covered wages is less than \$3,000 would the distinction come into play. If his income from these other sources amounts to at least \$3,000, the maximum tax base, there will be no need for making the allocation because all further amounts of income will automatically fall outside the self-employment tax base.

3. Rents

As in the case of dividend, interest and royalty income, rents are frequently attributable, in varying degrees, to the personal services of the proprietors. Some owners spend considerable time in making repairs and otherwise maintaining and managing their rented property. Accordingly it would seem logical to apply the same treatment to this item of income as is contemplated in the case of dividends, interest and royalties.

Efforts were made to distinguish between that rental income which is predominantly investment income and that which is substantially work-connected. The use of the "trade or business" yardstick, which is adequate in the case of dividends, interest, and royalties, seemed too comprehensive when applied to rents in the light of recent court decisions holding that real estate rentals, even in the case of a single residence, are now considered income from the conduct of a trade or business under the Internal Revenue Code.

The foregoing considerations suggest that the possibility of formulating a practicable rule for the administration of the desired distinction in the case of real estate rents was extremely remote. Of the two remaining alternatives, either to include or to exclude all such rents from the self-employment tax base, the latter appears to be preferable. In the average case, real estate rents are essentially a return on capital which, presumably, will continue after the proprietor's retirement.

It is not clear whether a statutory exclusion of "rentals from real property" would necessarily apply to boarding houses and hotels. It is believed, however, that the receipts in those cases might be properly classified by way of regulations as falling outside the excluded category.

4. Capital gains and annuities

The proposed tax base excludes all capital gains (and losses) since this item is clearly not earned income. This may exclude some items of work-connected income, as in the case of a trader whose profits take the form of capital gains. However, if allowance were made for such exceptions, it would entail complications to a degree deemed highly undesirable. Gains and losses from the sale or exchange of property other than capital assets which is used in the taxpayer's trade or business, also are to be excluded from the tax base. Annuities would be similarly excluded.

5. Net operating losses

With a view to averaging incomes in good and bad years, the income tax allows operating losses sustained in other years to be deducted in arriving at net income. This deduction would not be permitted for social security tax purposes. If the averaging of income achieved by the net-operating loss provision were applied for purposes of the self-employment tax, the self-employed person would be treated inequitably. He would not only fail to receive credit in his social security account for the year in which he sustained the loss, but his credit (and tax) for the year in which he had a profit would also be reduced by virtue of that loss.

To eliminate the net operating loss from self-employment income, the income tax return would be altered. This item would be removed from Schedule C and a new schedule would be inserted on the return to provide for the reporting of the net operating loss deduction.

6. Partnership profits

The rules described above for the inclusion and exclusion of items of income would apply to income derived by an individual from a partnership, syndicate, and joint venture. This would require some changes in the partnership income tax return (Form 1065).

7. Adjustment for taxable wages

In some cases, a self-employed individual may also be employed as a wage earner in an industry covered by the existing old-age insurance program. It would be necessary therefore to provide for an adjustment of self-employment income in order that the total taxable income during the year, including covered wages, did not exceed \$3,000. In the absence of such an adjustment, individuals might be taxed on more than \$3,000 in any year but receive benefits based on earnings of no more than that amount.

It should be noted that this coordination between the proposed tax on self-employment income and the Federal Insurance Contributions Act is not extended to other Federal retirement programs. Unless some action is taken to prevent duplication, it will be possible for a self-employed person to obtain credit and pay contributions toward railroad retirement benefits or civil service retirement benefits at the same time as he pays tax and obtains credit for his self-employment income. Similar duplication is possible now, however, in the case of wage earners.

B. Exemption from tax

The existing old-age insurance program applies to all wage earners in covered industry regardless of how small their individual wages may be. Under the income tax, the taxpayer is allowed a \$500 exemption and a similar exemption for each dependent member of his family. In fitting the proposed old-age insurance plan for the self-employed to the income tax, it would not be appropriate to carry over the present income tax exemptions. If this were done, a large number of self-employed persons would be excluded from the program. The other extreme, covering all self-employed persons no matter how small their self-employment income, would likewise be impractical. Although the present tax on wages for old-age insurance applies to more than 45 million workers, use of the withholding mechanism makes it possible to collect taxes from these people by dealing with only about 2-1/2 million employers. A solution lies somewhere between these two extremes and should be determined by balancing administrative costs and taxpayers' compliance difficulties against the desirability of the broadest possible coverage.

A choice which readily suggests itself is the adoption of a \$500 exemption per taxpayer, that is, to exclude from the tax and from coverage those individuals with self-employment income aggregating less than \$500 (regardless of the size of their family). It will be recalled that for two years during the war, the normal tax provided for an exemption of this amount. Such a provision would bring under the system an estimated 8.9 million persons in 1947. The principal objection to an exclusion provision of \$500 self-employment income is that, as compared with an alternative discussed below, it would exclude approximately 1.6 million persons who are most in need of old-age security. This group consists principally of farm operators, but also includes independent workers in urban areas. The number excluded would vary with the general level of business activity, and in a year such as 1939 might reach 2 million. Another disadvantage of the \$500 exclusion is that in a number of cases the self-employment tax will not be collected on self-employment income which will have been reported for income tax purposes. For example, a wage earner with a total income of \$2,500 who reports two or three hundred dollars of self-employment income for income tax purposes would not be required to file a self-employment tax return because of the \$500 exclusion. While the wage earner will generally be in the social security system, the collection of self-employment tax on his additional earnings, and the additional credit resulting therefrom, would constitute little additional burden to the administrative authorities.

An alternative exclusion might be \$200 of self-employment income, with a proviso that the self-employed person must have at least \$500 of gross income (i.e., is required to file an income tax return). This would bring under the system an estimated 10.5 million persons. However, in the view of the tax administrative authorities, such an exemption would raise a number of serious problems. It would involve the collection of tax from many individuals who are not liable for income tax because of personal exemptions and credits for dependents, and who characteristically do not file income tax returns, although their income exceeds the amount established as the filing requirement. Enforcement of the self-employment tax on such persons would require additional administrative personnel, at a cost that would be relatively high in relation to the additional taxes collected. The extent of such added costs would vary with the interest of these individuals in acquiring coverage. Although the amount of tax due would be small under the lower exemption, many would be unable to pay it, notwithstanding the Government's efforts to collect it. Finally, it may be noted that the lower exemption would enable individuals who have no self-employment income to acquire coverage at a very low cost merely by reporting \$200 of such income. So long as coverage is not complete, there will be an incentive for persons

outside the system to report fictitious income. However, as the coverage of the system approaches completeness very few people would need to resort to this device since they would have coverage on the basis of other employment. Although some safeguards may be erected, it would be impractical for the administrative authorities to prevent all reporting of fictitious self-employment income. These considerations also apply to some extent in connection with the higher exemption, but the magnitudes involved would be different.

As stated earlier, the degree of coverage under the social security system is largely a question of administrative costs. Substantial extension of coverage is attainable provided only that additional personnel is made available. However, the determination of the extent of additional coverage is a matter for Congressional determination in the light of administrative cost on the one hand and social and economic desirability on the other.

C. Tax rate

The old-age and survivors insurance program is now financed by a 2 percent tax on wages, one-half imposed on employees and one-half on employers. In the case of the self-employed, there is no employee-employer relationship, and it is necessary to determine whether the tax should be imposed at the employee rate of 1 percent, the combined rate of 2 percent, or at some compromise rate. The decision involves equity and administrative considerations.

Although to date public policy on financing the social security program has not fully crystallized, the Congress has determined, with respect to existing coverage, that 2 percent of covered earnings shall be collected from earmarked taxes. Since the proposed plan of coverage, as indicated at the outset of this report, is based on the assumption that it must fit into the existing social security framework, it follows that the revenue goal of the plan should be 2 percent of self-employment income. If the proposed tax falls short of this goal, it is because considerations other than financing are relevant to the problem.

From an economic and equity viewpoint, it is desirable that social security taxes should not put an employer at an advantage compared with a competing self-employed person. Nor should it alter the balance of factors which determine whether an individual becomes or remains a self-employed person rather than an employee. However, the effects of neither the present social security taxes nor of the proposed self-employment taxes can be assessed with sufficient precision to determine how the relative position of the various groups would be changed by these taxes. The economic effects of social security taxes depend upon the direction and extent of shifting. Given the great variety of prevailing economic relationships, there can be no uniform pattern of shifting of the proposed self-employment tax. Part of the difficulty of

determining a tax rate for the self-employed lies in the fact that the self-employed person presumably performs the economic functions of both the employee and the employer. If we compare the self-employed person in his role of businessman with the employer of labor, we are led to the conclusion that he should be subject to the equivalent of the employer tax. And if we compare the self-employed person in his role as worker with an employee, we are led to the conclusion that he should be subject to equivalent of the employee tax. And yet there is a lack of realism in attributing such a dual economic personality to all self-employed persons. Very frequently the economic position of a self-employed person is so much like that of an employee that a distinction between them can be drawn only on the most tenuous grounds. Because of the heterogeneous composition of the self-employed groups, it would seem desirable to levy a tax that is somewhere between the employee rate and the combined employee-employer rate. For example, the rate might be 1 percent on the first \$500 or \$1,000 or some other specified amount of self-employment income and 2 percent on the balance. ^{1/}

Another equity consideration which tends to support a compromise rate is the fact that the employer tax is a deductible expense for income tax purposes, while the proposed self-employment tax is not to be deductible for income tax purposes. The deductibility of the social security tax insures that the employer, so long as he is subject to income tax, will shift part of the social security tax to the Government, if it is not shifted elsewhere. The self-employed will not have the opportunity to shift part of the cost to the Government in the form of a lower income tax.

D. Other considerations

1. Joint returns

It is contemplated that in the case of a joint income tax return of a husband and wife, a self-employment tax return would be filed only by the spouse having self-employment income. If both spouses had such income, however, each would report self-employment income separately.

2. Community property

At present the salary or wage income of a married couple in a community-property State may not be arbitrarily divided between the two spouses for purposes of the social security tax, although it may be split between them for income tax purposes. Only the spouse earning the salary pays social security tax, and he alone receives credit toward

^{1/} If the present tax rates with respect to employment were increased, simultaneous changes in the corresponding rates on self-employment would also be increased.

social security benefits. This principle would also be applied to self-employment income. To depart from it would provide some groups an undue advantage and would distort the pattern of benefit payments now in the law. To adhere to this principle involves some compliance problems. However, the self-employment income to be reported for self-employment tax purposes must normally be determined before any allocation is made between the spouses for income tax.

It does not follow that a husband and wife in a community-property State could not each have self-employment income and acquire eligibility for benefits in his own right. Each spouse may indeed be subject to the self-employment tax because each has self-employment income.

The general rule suggested is that the income from a trade or business shall be treated as the income of the spouse who has the management and control of the trade or business irrespective of State law. If both spouses have the management and control of the trade or business then so much of the income as is attributable to the services or property of each spouse would be treated as the self-employment income of that spouse. This rule would be applied in cases of joint tenancies, tenancies by the entirety, and joint undertakings as well as to community-property income.

3. Partnerships

The "management and control" rule for allocating business income between spouses would not disturb the allocations of income of a genuine husband and wife partnership. Such a partnership, if recognized for income tax purposes, would be valid for social security tax purposes.

4. Accounting periods and methods

Income tax returns are sometimes filed on a fiscal year basis or for part of a year. Consequently, the self-employment tax would also cover periods other than a full calendar year. It would be necessary therefore for the Social Security Administration to make allocations of income, for benefit purposes, to quarters within a calendar year straddled by a fiscal year return. Similarly, it would be necessary for the Social Security Administration to allow for the accumulation on self-employment income credits on the basis of the various accounting methods used in the determination of taxable income under the income tax, such as cash, accrual, percentage of completion, crop, completed contract and instalment basis. Part year returns present a problem in connection with the \$3,000 maximum tax base. In order to obviate the possibility that an individual will be taxed in any year on more than \$3,000, the limitation would be prorated for part year returns.

5. Exclusion of nonresident citizens, aliens, etc.

It is, of course, possible for nonresidents of the United States to conduct a trade or business here and to derive self-employment income. However, it is not conceived to be the function of the social security program to provide retirement and survivors benefits to such individuals. It is therefore contemplated to exclude from coverage nonresident aliens and persons who are bona fide residents of a foreign country for the entire taxable year. There would also be excluded from the tax base income derived by a United States citizen from sources within a United States possession if such income is not subject to the income tax. 1/

6. Tax decisions to be binding for credit purposes

Since the self-employment tax is to be based upon income reported for income tax purposes, it follows that decisions as to what constitutes taxable income, or on the allowance and disallowance of certain items of deduction, should be equally binding for both taxes.

It is also important that the decisions made for tax purposes should be equally applicable for purposes of crediting an individual's social security account. Otherwise, the Bureau of Internal Revenue may rule one way on say, the deductibility of a given expenditure, while the Social Security Administration may rule another way. Such inconsistency may arise at present in connection with wage earners, because each agency is empowered to place an independent construction on identical statutory language. This is unsatisfactory now, but it would be far worse if a similar situation were to exist with respect to income tax concepts. It is therefore suggested that the Social Security Administration be specifically bound to adopt the decisions made by the Bureau of Internal Revenue with respect to any problem arising under the self-employment tax which might involve an interpretation of the income tax provisions of the Code.

1/ Section 251 of the Internal Revenue Code provides for the exclusion from gross income of all the income derived from sources outside the United States (and not received within the United States) by a citizen who (1) derived at least 80 percent of his gross income from sources within a possession of the United States, and (2) derived at least 50 percent of his gross income from the active conduct of a trade or business within a possession of the United States.

7. Reporting of self-employment tax

As heretofore indicated, the self-employment tax will be computed generally on the basis of data also required for income tax purposes, and it is contemplated that both taxes will be returned to the collector of internal revenue at the same time. The transfer of data from the income tax form to the self-employment tax form and the mechanics of computing the self-employment tax are illustrated by the items and explanations set out in Appendix B.

APPENDIX A

DETAILED COMPARATIVE DESCRIPTION OF PLANS FOR
COVERAGE OF AGRICULTURAL AND DOMESTIC EMPLOYEES

1. - MAILING, PRINTING, AND OTHER
MECHANICAL OPERATIONS

Plan I
Present System

Plan II
Book-Return System*

Plan III
Stamp System*

A. Publicity and initial
applications

Leaflets will be distributed to all likely agricultural and domestic employers (approximately 10 million) outlining liability of employers under the new law and enclosing post card applications (similar to Form SS-4) for employers' identification numbers.

Same as Plan I

Same as Plan I, except that there would be no employer identification numbers.

All agricultural and domestic employers and employees will be advised by radio and through the press relative to the securing of social security account numbers.

Same as Plan I

Same as Plan I

The employer applications will be preaddressed to the Collectors of Internal Revenue, and will disclose, among other things, the number of agricultural and domestic employees on each employer's pay roll.

Same as Plan I

On receipt of such applications, the collectors will forward to the employer a sufficient number of applications for employee social security account number (Form SS-5), for distribution to his employees. He will also receive the number assigned to him. (Form SS-6)

Same as Plan I, except that the employee application for an account number would also constitute a request for a wage book.

Same as Plan I, except that the employee application for an account number would also constitute a request for a stamp book.

* Both Plans II and III contemplate that a number of large employers would follow the procedures described in Plan I.

On receipt of the application filed by an employee, the Social Security Administration will send him a card bearing the social security account number assigned to him.

Same as Plan I, except that the employee would also be sent a wage book.

Same as Plan I, except that the employee would also be sent a stamp book.

B. Tax returns

Toward the close of each calendar quarter a tax return (Form SS-1a), in duplicate, will be mailed by the collector to each employer. On receipt of the tax return from the employer the wage data schedules will be detached by the collectors and transmitted to the Social Security Administration for posting of wage credits to the accounts of the employees listed.

Same as Plan I, but in addition forms would be sent to the employer once a year (and upon request) for use in case an employee does not submit his wage book to the employer.

No provision for quarterly tax returns. Tax will be paid at the time stamps are purchased from post offices and collectors offices. There will be available at these offices special forms to which to attach stamps, in cases where the employee fails to submit his stamp book to the employer.

C. Periodic issuance of books

No provision

Toward the end of each year, the Social Security Administration will issue a new wage book to each employee. Each book contains a detachable application for a new book, indicating the employee's current address.

Same as Plan II, except that a new stamp book would be issued every six months by the Social Security Administration.

2. - EMPLOYERS' BURDEN

Plan I
Present System

Plan II
Book-Return System

Plan III
Stamp System

A. General procedure

In addition to computing and withholding the employee's tax and

In addition to computing and withholding the employees' tax and

In addition to computing and withholding the employees' tax and paying

paying a similar tax himself, the employer must (1) apply for an identification number, (2) keep a quarterly record of his employees' names and social security account numbers as well as the wages paid to each, (3) on the basis of such record, fill out a Schedule showing the necessary wage information for each employee, (4) fill out a tax return showing total wages paid and taxes due, and (5) forward the return, the schedule and tax remittance to the collector within the month following the end of the quarter.

In the case of an employee who does not have an account number, the employer must attach to his return a form showing identifying data relative to such employee.

At least once a year, or at the termination of employment, the employer must furnish each of his employees with a statement showing the total amount of his wages and employee's tax for the period covered by such statement.

paying a similar tax himself, the employer must (1) apply for an identification number, (2) enter on each pay day in every employee's wage book, the amount of wages paid and his initials, (3) enter the amount of wages on a companion slip, removed from the book and retained until the end of the quarter (see p. 35 for specimen page in wage book), (4) fill out a quarterly tax return showing total wages paid during the quarter and taxes due, and (5) forward the return, the wage slips in his possession, and the tax remittance to the collector within the month following the end of the quarter.

Same as Plan I, except that form would also be used if employee failed to present his book to the employer for wage entries.

No provision for receipts other than that represented by employers entry in wage book.

a similar tax himself, the employer must (1) requisition and purchase stamps in advance of paying wages, (2) affix the proper number of stamps on the appropriate page of each employee's stamp book every pay day, and (3) cancel each stamp by initialling.

Same as Plan II

No provision for receipt other than that represented by stamps in the employees' book.

B. Special cases

No need for special treatment of any groups.

Employers may, with the consent of the Commissioner, elect to dispense with the use of employee books and to follow the same procedures as under Plan I. Such employers who have commercial and agricultural or domestic employees would include the total wages of both groups in the tax return now required on account of their commercial employees. Attached to the return would be the wage schedule for his commercial employees and the wage slips for agricultural or domestic employees.

Large employers and others, upon application to the Commissioner, would be permitted to include all of their employees in their quarterly returns on Form SS-1a. Such employers will not have to affix any stamps in the books of their agricultural workers but must enter therein at least every six months the total wages paid to such employees during the intervening period.

3. - EMPLOYEES' BURDEN

Plan I
Present System

Employees' only duties will consist of filling out and filing their applications (Form SS-5) for social security account numbers, and of informing employers with respect to such numbers.

Plan II
Book-Return System

In addition to filling out and filing their applications for a wage book and social security account number, employees must remember (1) to carry their wage books with them every pay day, and (2) to present them to their employers for appropriate entries (unless the books are left with the employer), (3) apply for a new book near the end of the year, giving any change of address, (4) sign their old wage books and send them to the Social Security Administration after the close of the year.

Plan III
Stamp System

Same as Plan II, except that new books would be applied for every six months instead of annually.

In case an employee loses or destroys his wage book or fails to receive a book from the Social Security Administration, he must promptly notify the Social Security Administration thereof.

Same as Plan II

Whenever an employer fails to make entries in his wage book, the employee must write in the amount of wages, the date of payment, and name of employer, on a page designed for the listing of delinquent employers.

Same as Plan II

4. ENFORCEMENT

Plan I Present System

Enforcement of the employees' and employers' taxes imposed by the Federal Insurance Contributions Act will be undertaken by the Internal Revenue Service and will be primarily dependent upon employer willingness to comply.

Plan II Book-Return System

Same as Plan I, but in addition, the employee and the Social Security Administration will be in a position to assist in assuring compliance by employers.

Plan III Stamp System

Enforcement under this system will depend primarily upon employers' acceptance of the stamp plan, employees' efforts to insure compliance by their employers, and the efficiency of the Social Security Administration in issuing and processing stamp books.

A. Regular contact with employer

The mailing of Form SS-1a shortly prior to the end of each calendar quarter, will be a reminder to each employer of his recurrent liability.

Same as Plan I

No provision for regular contact with employer.

B. Spot checks and audits

Agricultural employers who take a deduction for wages in their income tax returns should not present any substantial enforcement problem in view of the disclosures which such employers are required to make in their income tax returns.

In the case of domestic employers, and of farmers who do not file income tax returns, efforts will be made by way of periodic radio broadcasts, spot checks and audits by deputy collectors, and by action on complaints (when practicable) to insure adequate compliance. Assessment lists covering prior periods will be available for such spot checks as may be deemed advisable. The requirement that the employers maintain a record of their pay rolls should assist in the completion of whatever audits are deemed necessary.

C. Employee participation

Employees would be free to remind their employers to withhold the social security tax, to file quarterly tax returns and furnish annual or termination wage statements. In addition they would be free to check on employer compliance by ascertaining from the Social Security Administration the wages credited to their accounts.

Same as Plan I

Same as Plan I, except that since employers will not be required to keep wage records (other than a copy of the tax return showing total wages), completion of an audit may require securing copies of wage reports from the Social Security Administration, involving delay.

This system does not lend itself to effective spot checks or audits by the Internal Revenue Service or the Social Security Administration.

Employer entries in wage books each pay day would be a reminder to employers to file quarterly returns, and that such wage books when filed with the Government may disclose non-compliance.

The books presented by employees would be a reminder to employers to obtain the necessary stamps.

Employees' wage books will be examined by the Social Security Administration to ascertain cases of non-compliance. Delinquencies will be checked by the Social Security Administration and, if substantiated, will be referred to the Internal Revenue Service for such action as is deemed practicable (unless, in pursuance of existing policy, enforcement action must be undertaken in each such case).

Employees' failure to return their wage books to the Social Security Administration, and present their books to employers will require some action by the Social Security Administration.

On receipt of complaints regarding employers' noncompliance, the Social Security Administration will conduct preliminary investigations and, in the event of delinquency, will report its findings to the Internal Revenue Service for action. Action by the Internal Revenue Service will depend upon the amount of the deficiency involved, the degree of willfulness, or the likelihood of recurrence.

Same as Plan II; investigations by the Social Security Administration will be particularly necessary in the case of an annuitant.

5. TAXPAYER RESISTANCE AND INERTIA

Plan I Present System

Plan II Book-Return System

Plan III Stamp System

A. Employers

The failure of housewives and farmers to keep records, the burden of filling in and filing quarterly returns on Form SS-1a, and the average housewife's complete lack of tax experience and tax responsibility, will present difficulties in the enforcement of this system. However, employers who have regular full time employees will have

The remarks about Plan I are fully applicable to Plan II, since Plan II would include the same taxpayers. However, to the extent that Plan II operates to reduce the record keeping requirements of housewives and small farmers, enforcement may be improved. In addition, employees may be expected to assist in enforcement.

The remarks about Plans I and II are applicable to Plan III. However, there would be less enforcement pressure from the income tax, because there would be no social security tax return to check against income tax deductions. To the extent that the mechanics of acquiring and affixing stamps is more distasteful than filing returns.

developed a close relationship with them, and it is unlikely that such employers will resist a system designed to provide OASI to their employees.

Resistance or inertia can be expected from occasional employers. Unlike agricultural employment, the wages paid for domestic service are not deductible for income tax purposes. Hence, domestic employers may feel more free to conceal such wages. The same considerations will also be applicable in the case of the small farmer who does not file income tax returns, and who hires occasional help.

Employers in agriculture include hundreds of large organizations, some already subject to the present reporting system, which keep some record of the wages paid to their workers for purposes of the income tax deduction. Approximately 80% of agricultural workers are employed on only 600,000 farms. While the majority of such workers may be casual or part time employees, the employers occupy a fairly substantial economic status and are unlikely to jeopardize their income tax deductions by failing to comply with the social security tax.

Some housewives may resent having to handle soiled wage books, and farmers may resent making entries in their employees' books under field conditions.

and keeping records, it may engender some resistance not provoked by the other two plans. To the extent that employees fail to present their books, employers will find it difficult to comply.

The small and occasional employer in the agricultural as well as the domestic area may frequently neglect to purchase stamps for his employees' books, and he may never see the employee again. It is doubtful that the employer in such cases will send the stamps in directly to the Social Security Administration.

B. Employees

Many employees may fail to present their wage books to their employers on pay day, or to return them to the Social Security Administration. Such non-compliance will result from (1) negligence, (2) a desire to avoid the withholding of employees' tax and disclosure of income tax liability, and (3) fear that reporting their employer's delinquency might affect their jobs. It does not appear practicable to penalize employees for failure to use their wage books.

The likelihood of employee compliance is extremely difficult to determine. Most of the employees are part time or seasonal workers, and not being required to use their wage books steadily may either lose them or lose sight of their importance. A large number of workers will shift back and forth between employers who are required to make entries in their books and those who are not required to do so, giving rise to loss or disrespect for the books. Failure of an employee to present his wage book for proper entries might encourage some employers to omit such wages from their quarterly returns, a similar result may occur if the employer loses the wage slips detached during the quarter.

All of the considerations discussed under Plan II with respect to the attitude of employees are equally applicable under this system.

Moreover, the possibility of counterfeiting, and the possibility of inflating wage credits by purchasing and cancelling stamps themselves, might give rise to disrespect for revenue laws generally among such employees.

6. CORRECTIONS OF UNDERPAYMENTS

Plan I Present System

Underpayments could be determined with a fair degree of certainty because the employer would keep records of each employee's wages. The employer may voluntarily correct an underpayment by reporting the additional tax, without interest, as an adjustment on a return filed after the error is ascertained. If not voluntarily reported the additional tax may be assessed and collected under established routines. In either event the collector notifies the Social Security Administration of the exact corrections to be made in the employee's accounts.

Plan II Book-Return System

Because of the lack of employers' records, underpayments may not easily be determined. If the amount of the error is ascertained, however, an adjustment may be made in the same manner as under Plan I. Form SS-1c also may be used. Employees' books may not be available to employers to an extent sufficient to make them useful for voluntary corrections. Employees' reports of employer non-compliance would have to be screened against posted wage records before action could be taken.

Plan III Stamp System

Because of the lack of employers' records, and with no routine contact between the employer and the collector, the correction of underpayments will not be convenient. Employers may report additional taxes by obtaining a special form, but there will be no record kept to enable the employer to identify the employee or to report exact amounts of wages and taxes. Employees' reports of non-compliance should be screened against employers' voluntary reports before action is taken.

7. CORRECTIONS OF OVERPAYMENTS

Plan I Present System

The maintenance of records enables the employer to determine overpayments with a fair degree of certainty. The employer may correct an overpayment by deducting the amount thereof from tax due on a subsequent return. Before making such a deduction of employees' tax the employer must reimburse the

Plan II Book-Return System

Same as Plan I except that the absence of employers' records will create difficulties in the computation of overpayments and the correction of erroneous wage records. The Social Security Administration will receive numerous requests for photocopies or transcripts of employers' returns.

Plan III Stamp System

Because of the lack of employers' records, and the fact that the employee's stamp book is the sole device for tax payments, there is no practicable method for correcting overpayments by means of deductions. Accordingly, overpayments can be corrected only by means of refunding procedures.

employee or obtain his written consent to allowance of the deduction. The overpayment also may be corrected by means of a claim for refund filed by the employer or the employee. The collector notifies the Social Security Administration of the exact wage record corrections to be made.

Under this system, the purchaser of unused stamps may obtain cash by filing a claim for redemption with the collector. If the stamps are lost or destroyed, the value of the stamps and proof of loss must be established.

APPENDIX B

ITEMS FOR COMPUTATION AND REPORTING OF SELF-EMPLOYMENT TAX

1. Enter here your net profit or loss from business or profession, including farming, but excluding rentals from real estate. (See paragraphs 1 and 2 of explanation below.).....\$ _____
2. If you are a member of a partnership, syndicate, pool or joint venture which had net profit or loss from a business or profession (excluding the rental of real estate), during taxable year, enter here the amount of such profit or loss. (See paragraphs 1 and 3 of explanation below.).....\$ _____
3. Enter here net total of items 1 and 2\$ _____
4. Enter here wages received by you during the taxable year as an employee on which your employer or employers were required to pay tax under the Federal Contributions Act. (If this amount is \$3,000 or more no self-employment tax need be reported.).....\$ _____
5. Subtract amount in item 4 from \$3,000 and enter the difference here. (If amount in item 4 is zero enter \$3,000.).....\$ _____
6. Enter here the amount in item 3 or item 5, whichever is smaller. (This is your taxable self-employment income.).....\$ _____
7. If the amount in item 6 is \$1,000 or less enter here 1 percent of such amount. If the amount in item 6 is in excess of \$1,000 enter here \$10 plus 2 percent of the amount of such excess. (This is your self-employment tax.).....\$ _____

EXPLANATION OF FOREGOING ITEMS

1. Husband and Wife.--Regardless of whether husband and wife make a joint income tax return on Form 1040, or reside in a state or territory the law of which treats earnings of husband and wife as community property, each spouse must report separately the amount of self-employment income derived from a business or profession, other than the rental of real estate, carried on by such spouse. If the business or profession is under the management and control of only one spouse, all of the net profits therefrom shall be included in the self-employment income of that spouse. If the business or

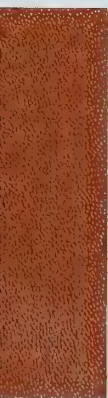
profession is under the management and control of both spouses, each spouse must include in his or her self-employment income only that portion of the net profits which is attributable to the services or property of such spouse. In case of a partnership each partner shall report separately in accordance with paragraph 3 below.

2. Rules for Filling in Item 1.--If you are reporting all of your business or professional income in Schedule C of Form 1040 for income tax purposes, the amount to be entered in this item should be the same as that amount (excluding real estate rentals and net operating loss deduction) which you are required to enter in such Schedule C. If you are reporting any business connected royalties in Schedule B of Form 1040 you must include such royalties in the amount to be entered in this item.

3. Rules for Filling in Item 2.--If you were not a member of a partnership, syndicate, pool, or joint venture which realized income from a trade or business during the taxable year, you should enter zero in this item. If you were a member of such an organization, you must enter the amount (excluding real estate rentals) which you are required to report in Schedule E of your income tax Form 1040.

4. Rules for Filling in Item 3.--Enter in this item the net total of items 1 and 2. If amounts in both items 1 and 2 represent profits, the sum of such amounts must be entered here. If the amounts in items 1 and 2 both represent losses, or if a loss in one item is greater than a profit in the other of such items, then you should enter zero in item 3.

5. Rules for Filling in Item 4.--If you received wages during the taxable year as an employee on which your employer or employers were required to pay social security tax under the Federal Insurance Contributions Act (old-age and survivors insurance tax), the entire amount of such wages should be entered in this item, UNLESS such wages amount to \$3,000 or more, in which case you are not required to report or pay self-employment tax.



80th Congress }
1st Session }

SENATE COMMITTEE PRINT

DIGEST OF ISSUES IN SOCIAL SECURITY

A DIGEST OF THE REPORT SUBMITTED IN
JANUARY 1946 TO THE COMMITTEE ON
WAYS AND MEANS, HOUSE OF REPRESENT-
ATIVES, BY THE TECHNICAL STAFF,
ESTABLISHED PURSUANT TO H. RES. 204,
79TH CONGRESS, FIRST SESSION, WITH STA-
TISTICAL REVISIONS AND REFERENCES TO
SUBSEQUENT DEVELOPMENTS



Printed for the use of the Committee on Finance

COMMITTEE ON FINANCE

EUGENE D. MILLIKIN, Colorado, *Chairman*

ROBERT A. TAFT, Ohio

HUGH BUTLER, Nebraska

OWEN BREWSTER, Maine

HARLAN J. BUSHFIELD, South Dakota

ALBERT W. HAWKES, New Jersey

EDWARD MARTIN, Pennsylvania

WALTER F. GEORGE, Georgia

ALBEN W. BARKLEY, Kentucky

TOM CONNALLY, Texas

HARRY FLOOD BYRD, Virginia

EDWIN C. JOHNSON, Colorado

SCOTT W. LUCAS, Illinois

SHERWOOD B. STANLEY, *Clerk*

[This digest of Issues in Social Security was prepared for purposes of information and discussion by the Advisory Council on Social Security in its study of the social-security program pursuant to S. Res. 141, 80th Cong., 1st sess. It has not been reviewed by the Committee on Finance or by any member prior to printing.]

DIGEST OF ISSUES IN SOCIAL SECURITY

FOREWORD

This digest of Issues in Social Security has been prepared for the use of the members of the Advisory Council on Social Security appointed by the Committee on Finance, United States Senate, in accordance with Senate Resolution 141, Eightieth Congress, first session.

Issues in Social Security is a report submitted to the Committee on Ways and Means of the House of Representatives in January 1946. The report organized and analyzed the available data on old-age and survivors insurance, public assistance, and unemployment insurance, and pointed out problems in the field of social security.

The report was prepared in 1945 by the Social Security Technical Staff established pursuant to House Resolution 204, Seventy-ninth Congress, first session. The members of the Social Security Technical Staff who prepared the report and their affiliations at the time were: Chief of staff, Leonard J. Calhoun, commander, United States Naval Reserve; John J. Corson, director of research of the Washington Post; William R. Curtis, chief, administrative standards division, Bureau of Employment Security, Social Security Board; F. F. Fauri, director, Michigan State Department of Social Welfare; George W. K. Grange, reference assistant, actuarial division, Metropolitan Life Insurance Co.; and Rainard B. Robbins, vice president, Teachers Insurance and Annuity Association.

The preparation of this digest of the report was under the general supervision of Mr. Fauri, now senior specialist, Legislative Reference Service, Library of Congress. The digest of part I, relating to old-age and survivors insurance, was prepared by Mr. Grange; and the digest of part III, relating to unemployment compensation, by Mr. Curtis. The digest of part II, relating to public assistance, was prepared by Donald S. Howard, director of social work administration, Russell Sage Foundation, and reviewed by Mr. Fauri. All three parts were reviewed by Mr. Calhoun.

The digest includes some current data bringing the material in Issues in Social Security up to date.

NOVEMBER 7, 1947.

TABLE OF CONTENTS

	Page
Foreword.....	iii
Part I. Old-age and survivors insurance.....	3
Chapter I. Development and present provisions.....	3
Chapter II. Extension of old-age and survivors insurance coverage.....	3
The self-employed.....	5
Agricultural labor.....	7
Domestic service.....	7
Nonprofit organizations.....	7
Civilian Federal employment.....	8
Public employment other than Federal.....	8
Railroad employment.....	9
Cost of extending coverage.....	9
Chapter III. Coverage of military service and adjustment of duplicate benefits.....	10
Chapter IV. Liberalizing old-age and survivors insurance protection.....	10
Adjustment of existing OASI benefit amounts.....	10
Adequacy of present benefits.....	11
Liberalizing the benefit formula.....	12
Inclusion of extended disability benefits.....	13
A suggested initial step.....	14
Chapter V. Financing old-age and survivors insurance.....	15
Actuarial aspects.....	15
Tax policy.....	16
Choosing a method of financing.....	17
Tendency to liberalize benefits.....	18
Chapter VI. Miscellaneous.....	19
Benefit rights of new entrants into OASI.....	19
Elective OASI coverage.....	19
Voluntary annuities.....	19
The "retirement" requirement for OASI benefits.....	20
Reducing OASI age requirement for women.....	20
The three-times rule in financing OASI.....	21
Review of appendix to part I.....	21
Part II. Public assistance.....	25
Introduction.....	25
Experience since 1935 in the special types of public assistance.....	25
Persons receiving aid.....	26
Payments to recipients.....	26
Fiscal arrangements.....	27
Current provisions for needy persons not covered by the Social Security Act.....	27
Organization, supervision, and financing.....	28
Extent and amount of general assistance.....	29
A. More adequate aid.....	30
Average State payments.....	30
Inadequacies of present maximums.....	31
Relation of State maximums to Federal maximums.....	31
Payments limited to Federal ceilings.....	32
Changing or removing Federal maximums.....	32
Removal of Federal ceilings.....	32
Liberalizing Federal matching provisions.....	33

Part II. Public assistance—Continued	
A. More adequate aid—Continued	Page
Federal aid for medical care.....	33
The need for medical care.....	33
Effect of Federal maximums upon provisions for medical care.....	33
Effect of Federal participation only in money payments to individuals.....	34
Meeting health requirements.....	34
B. Extension of aid.....	35
Types of needy persons not currently assisted by federally aided programs.....	35
Need not covered by general assistance.....	35
Federal participation in aid to childless widows, the infirm, and employable persons unable to obtain work.....	36
A new title to the Social Security Act.....	36
Adjustment of eligibility requirements for aid to dependent children.....	37
State residence requirements.....	37
The problem of nonresidence.....	38
Suggested solutions of the problems of residence.....	38
Redefinition of economic reasons for eligibility.....	39
"Pensions".....	40
C. Variable grants.....	40
Variable grants to States.....	40
Comparative fiscal ability among States.....	40
Incidence of poverty.....	41
Varying Federal participation to State ability.....	42
Equitable distribution of funds within States.....	44
County differences in assistance payments.....	44
County fiscal burdens.....	44
D. Miscellaneous provisions.....	44
Limitation of liens.....	44
Federal participation in burial payments.....	45
Federal participation in cost of administration of old-age assistance.....	45
E. Related tables:	
Table 1. Recipients of public assistance, by program, 1936-47.....	46
Table 2. Average public-assistance payments, by program, 1936-47.....	46
Table 3. Recipient rates for public assistance in June 1945 and 1947, by program and by State.....	47
Table 4. Average monthly public-assistance payments in June 1945 and 1947, by program and by State.....	48
Part III. Unemployment compensation.....	49
Chapter I. The Federal-State system of unemployment compensation in the United States.....	51
Introduction.....	51
The purpose of unemployment compensation.....	52
Summary of operations under the Federal-State system.....	53
Unemployment compensation during the reconversion.....	53
Chapter II. The benefit structure in unemployment compensation.....	54
Weekly benefit amount.....	55
Duration of benefits.....	56
Potential benefits in a benefit year.....	56
Waiting period.....	57
Eligibility conditions.....	58
Disqualification from benefits.....	58
Chapter III. Coverage of unemployment compensation.....	59
Employees in small firms.....	60
Civilian employees of the Federal Government.....	60
Maritime workers.....	61
Agricultural workers.....	61
Domestic service.....	62
Nonprofit workers.....	62
Employees of State and local governments.....	62

TABLE OF CONTENTS

VII

Part III. Unemployment compensation—Continued	Page
Chapter IV. Financing unemployment compensation.....	63
Benefit financing.....	63
Administrative financing.....	65
The present method.....	65
Suggested changes.....	66
Conclusions.....	68
Public employment services.....	68
Chapter V. Issues in unemployment compensation.....	71
Related tables:	
Table 5. Maximum weekly and potential annual benefits, and qualifying wages for maximum benefits, by State, September 15, 1947.....	75
Table 6. Minimum weekly benefits and qualifying wages therefor, and potential annual benefits and duration of benefits for claimants who meet minimum qualifying requirements, by State, September 15, 1947.....	76

PART I. OLD-AGE AND SURVIVORS INSURANCE

PREPARED BY

GEORGE W. K. GRANGE

Reference Assistant

ACTUARIAL DIVISION, METROPOLITAN LIFE
INSURANCE COMPANY

PART I. OLD-AGE AND SURVIVORS INSURANCE¹

CHAPTER I. DEVELOPMENT AND PRESENT PROVISIONS

This chapter reviews the background, development, and present provisions of OASI. It thus serves as an introduction to subsequent chapters which discuss a number of basic problems.

P. 13
to 24

The original provisions of 1935 were substantially modified in 1939 so as to—

1. Increase early benefit payments and decrease later ones.
2. Add survivors' and dependents' benefits.

There were also limited changes in the employments covered.

The increase in the size of individual benefits granted and of annual total benefit outlays in early years and their decrease in later years was effected largely through (1) basing the benefits on average monthly wage received in covered employment (approximately during the period from January 1, 1937, or age 22 if later, to death or retirement), instead of on total wages received in covered employment from January 1, 1937, to age 65; (2) adopting insured-status requirements which would increase the numbers of eligible aged in the early years.

These changes, together with the new monthly benefits for survivors and dependents, meant that the trend of OASI development was clearly away from the concept of benefits in proportion to contributions with no provision for members of the family, and toward the concept of basic family protection through expanded social insurance.

Modifications of employments covered resulted in only a small net increase, in spite of recommendations for major extensions which were made in the 1938 report of an advisory council jointly appointed by the Senate Finance Committee and the Social Security Board.

Of significant changes indicated for OASI, extension of coverage is by far the most important. Without it, many serious limitations and inequities will remain however the system is otherwise improved.

CHAPTER II. EXTENSION OF OLD-AGE AND SURVIVORS INSURANCE COVERAGE

P. 25
to 58

This chapter discusses the present exclusions from OASI of areas of gainful employment—self-employment, agricultural labor, domestic service, employment for nonprofit or-

¹ Referred to subsequently as OASI.

ganizations, civilian public employment (Federal and other), and railroad employment. The basic significance of the exclusions in reducing the effectiveness of the system, the importance of extending coverage, and considerations in making the extension to each of the excluded classes are reviewed.

Major points developed are that—

1. About two out of five jobs, including self-employment, are not covered. P. 57

2. There is a high degree of shifting of workers between covered and noncovered jobs and unemployment (the so-called in-and-out movement), and each shift out interferes with the size or the availability of OASI benefits. P. 57 to 58

3. Availability of OASI benefits to all has been accepted from the start as a national objective, to be realized as soon as a variety of difficulties can be overcome.

4. The need, on the part of workers and their families, of some substitute for earned income that has disappeared is independent of the source of the earned income; hence the same potential benefits should be available to all regardless of occupation or changes in occupation of the breadwinner. Otherwise, the system fails in its purpose of providing a basic floor of protection against hazards all may face.

5. Not alone individuals and their families but society as a whole suffer through failure of a scheme to furnish the protection for which it was designed when it excludes substantial areas of employment.

6. The high degree of shifting of employees in and out of any particular employment will thwart any effort to operate parallel plans as a substitute for OASI. Even if the benefits were identical, such plans would involve unjustified expenditures of time and effort in making adjustments.

7. The prospect of the addition of other kinds of social-security benefits to OASI increases the importance of having OASI benefits available to all.

8. In industry, staff pension plans have been arranged on a large scale as supplements to OASI benefits. Similar arrangements can be made to advantage in all public employments and in railroad employment.

9. The only feasible method of eliminating the uncertainties of protection and the anomalous and inequitable situations that interfere with the attainment of the fullest social protection, is a general extension of OASI coverage to employments now excluded. Delay in this extension will result in greater rather than smaller problems.

10. Though a general extension of present coverage to all gainful workers will naturally involve a considerable increase in dollar costs, when costs are expressed in terms of pay roll, there should be little or no initial

difference, and ultimately there should be a substantial decrease.

The figures and chart on page 26 of the report, showing the number of civilian workers in covered and excepted employments in an average week of 1944, indicate the significance of the exceptions from OASI coverage.

The charts on pages 27 and 29 and the figures on page 28 give quantitative indications of the plan's effectiveness (or lack of it) as reflected in the very substantial shifting between covered and noncovered employment and unemployment.

Two further marked illustrations of the extent of shifting are—

1. Normal withdrawals from Federal service: Up to June 30, 1940, five times as many participants under the civil-service retirement plan had withdrawn from service as had retired (see also chart on p. 43; figures on p. 30).

2. Railroad retirement experience: About 45 percent of persons who worked for the railroads in the period 1937-43 had left at least temporarily by the end of 1942 and about 40 percent of those employed in 1943 were newcomers in that year. Three times as many people have both railroad and OASI wage credits as were employed on the railroads at the end of 1944.

P. 30

After giving a number of hypothetical cases (pp. 31 and 32) to illustrate what could happen as a result of shifting, the report concludes:

Such are the anomalous situations that inevitably must arise under a social benefit plan of limited coverage. The line of demarcation between those who barely qualify for benefits and those who just fail to qualify is often tenuous. An ideal social benefit plan would rarely need to draw such lines. Perhaps there will always be room for improvement in a plan with only partial coverage, but limitations that are, unfortunately, essential under limited coverage will continue to interfere seriously with the fullest social good of such a plan. Such limitations can be dropped only when coverage is complete. Perhaps nothing short of complete coverage can be defended when we bear in mind that the presumed need that gives rise to a social benefit plan is independent of the classification of the employment of the breadwinner. At any rate, every exception from coverage is on the defensive as an obstacle to the social effectiveness of a national plan.

The chapter goes on to consider each excluded group in respect of (1) reasons for the original exclusion, (2) the group's need for the basic protection of OASI, and (3) methods of overcoming difficulties.

THE SELF-EMPLOYED

Reasons for exclusion.—Largely administrative. They have no employers to withhold contributions and make reports for them (though many make reports for their own employees).

P. 34
to 37

Need for coverage.—This is by far the largest single excluded group. About 9,000,000 persons receive their basic support from operating farms (about half), small businesses, and other unincorporated enterprises. Many more supplement their primary income with self-employment.

The self-employed have about the same opportunities for providing security for themselves, and therefore about the same need for OASI protection, as wage earners. Farmers are more likely than wage earners to have property, but their incomes are lower on the average. Urban self-employed average higher incomes than industrial and commercial employees, though frequently lower than employees doing the same kind of work. Shifting between employment and self-employment is substantial, often in the same year (particularly farmers).

Survivorship protection is important in the early years of a small proprietor's business when he is raising a family; old-age protection later on when, as often happens, the business fails and savings and property are lost.

Difficulties and their solution.—Difficulties chiefly relate to administrative feasibility. They are not insurmountable and their solution has been worked out. It is doubtful whether further delay would add anything of value, and it will certainly increase hardship cases.

As a rough approach to defining the income on which OASI tax is to be paid if self-employed are to be brought under the OASI plan, the report suggests that net income after a few clearly distinguishable and widely understood deductions, such as dividends, interest, income from annuities, pensions, estates and trusts, would afford a reasonable and administratively feasible basis of coverage. At any rate, it could certainly be better justified than the present situation where a substantial number of persons who engage in self-employment also engage in covered employment, but not to the extent necessary to qualify them for any OASI benefits. Though such persons are required to make OASI contributions, they fail to obtain an insured status under the plan. The report also suggests that the first \$500 of such net income be subject to the employee tax rate only, thereby affording some recognition to low-income groups and to failure to exclude return on capital business investments from taxable income. Above the \$500 figure the joint employer-employee rate could apply.

It is further suggested, as a means of reducing administrative difficulties, that in years of low net income—below \$500 a year, say—self-employed individuals be exempt from the tax. As a result they would not be given any wage credits for such years. This would reduce the problems of (1) locating many who have never been subject to income tax and (2) collecting from individuals with below-subsistence incomes.

Experience might then indicate the feasibility of further extension below the \$500 level, depending on such imponderables as popular understanding of the significance of the coverage, and the purpose and effect of the social-security tax.

AGRICULTURAL LABOR

Roughly 4,000,000 persons work as hired farm laborers during a year, but the seasonal low point is about one-third that number. P. 37 to 38

Reasons for exclusion.—Largely administrative, together with original lack of enthusiasm on the part of both workers and farm operators.

Need for coverage.—Particularly important as—

1. Many also work in covered employment (seasonally, or as a result of normal migration from the farm) but with insufficient coverage for protection, or with reduced protection.
2. They have low and uncertain incomes.
3. Many have family responsibilities—greater on the average than city dwellers.
4. Their old age or death frequently means that the community must provide assistance.

Difficulties and their solution.—Certain administrative difficulties are perhaps greater for agriculture than for industry, e. g., initial procedures in reporting and collecting; uncertainty as to existence of an employer-employee relationship, or as to identity of the employer (farm owner, farm tenant, etc.). However, their coverage has been facilitated by (1) success in overcoming similar initial difficulties for other employees and (2) the fact that it would involve contact with only about one-third—and the most substantial third—of farm operators. Since they are wage earners, agricultural workers, and packing and processing workers (now excluded by the definition of agricultural labor in the act) may be included with the same tax base and tax rate as apply to presently covered workers.

DOMESTIC SERVICE

The numbers involved vary considerably with economic and employment conditions. From the standpoints of need for OASI coverage and of administrative problems they are in much the same position as farm labor. P. 38

NONPROFIT ORGANIZATIONS

Charitable, religious, educational, etc.—roughly about a million persons. P. 38 to 41

Reasons for exclusion.—Originally, fear of endangering freedom from taxation and separation of church and state.

Need for coverage.—The same, by and large, as presently covered employees.

Difficulties and their solution.—There are no special administrative difficulties. In evaluating the argument that the OASI tax would jeopardize tax-exempt status, it should be remembered:

1. That this tax differs basically from ordinary taxes in purpose and in the effect of exemption (viz, to exempt

the employee from the protection normally afforded working people and to excuse the employer from contributing).

2. Some nonprofit organizations, exempt from other Federal taxes, have to date been subject to the OASI tax without their other exemptions being affected (e. g., exemptions under sec. 101 of the Internal Revenue Code).

To remove the fear that separation of church and state will be endangered, the report suggests that consideration be given to:

1. Excusing churches from the ordinary processes of tax liability.
2. Exempting ministers and members of religious orders from coverage.

CIVILIAN FEDERAL EMPLOYMENT

Two million nine hundred thousand persons as of April 1, 1945, including 2,000,000 in war agencies.

Reasons for exclusion.—The civil-service retirement plan already covered the majority and a number of minor plans covered particular small groups.

Need for coverage.—Extensive shifting between Federal and industrial employment.

Difficulties and their solution.—The fear has been expressed that, with an OASI tax rate scheduled to reach 3 percent by 1949, any attempt to make the civil-service plan supplementary to OASI would mean annihilation of the former plan, since it would be feasible to levy only very small contributions for its support. To counter this fear, it is suggested that if OASI taxes become 1½ percent (for the period 1947-56, as recommended under financing)² contributions under the civil-service plan be 3½ percent of salary up to \$3,000 a year and 5 percent of any excess over \$3,000 a year.

The pros and cons of attempting a solution through broadening the civil-service plan and coordinating it with OASI are discussed at some length in the report (pp. 45-48) and dismissed as unduly complicated and pointless.

A sketch of what might be a practicable modified civil-service plan in supplementation of basic OASI protection is presented on pages 49-51 of the report.

P. 41
to 52

PUBLIC EMPLOYMENT OTHER THAN FEDERAL

About 2.9 million persons.

Reasons for exclusion.—The Federal Government does not tax a State.

Need for coverage.—Shifting and general lack of retirement prospects.

Difficulties and their solution.—The indicated approach is coverage through Federal-State agreement, provided the State is ready and has the power to require its administrative departments and its political subdivisions to cooperate as employers in bringing employees under the act.

P. 52

² See footnote 7, pt. I.

RAILROAD EMPLOYMENT

About 1.4 million employees.

P. 53
to 56

Reasons for exclusion.—At the time social security was enacted in 1935 a special national system was being created by Congress for employees of railroads doing an interstate business.

Need for coverage.—Same as for most other employments—extensive shifting with weakening or loss of protection, or redundancy of benefits for those who qualify for both railroad retirement and OASI.

Difficulties and their solution.—The railroad plan resembles civil service through being in the main a staff pension plan (though with the social benefit characteristic of favoring the lower-paid employee).³ It differs from civil service in being Federal legislation to provide for employees of one particular private industry. As a staff plan it is unsatisfactory with respect to higher-paid workers. Both the social benefit needs of railroad workers and their families and the staff pension objectives can be met far more satisfactorily if separated. The complications of having them combined in one system and of coordinating that system with OASI are tremendous.

As in the case of Federal service, the report concludes that the most feasible remedy is basic coverage by OASI. Since this would be undesirable without modifying the railroad plan to make it a supplementary one like other industrial plans, a brief illustration is offered of what might be done in this respect (pp. 55–56).

COST OF EXTENDING COVERAGE

The table on page 56 affords a basis for the following rough conclusions as to the effect on costs of a general extension of coverage with no change in benefits:

P. 56
to 57

1. While over-all costs may perhaps be more than doubled at the start, they may eventually be not much more than 50 percent in excess of present estimates.

2. When benefit outlays are expressed in terms of pay-roll, extension of coverage brings about little initial change, but a substantial eventual reduction in percentage of pay-roll costs and accordingly of tax rates (on a current cost basis). This results from the greater weight that will attach in the benefit formula⁴ to the 10 percent of average wages in excess of \$50 (as compared with the 40 percent of the first \$50) when the in-and-out movement is greatly reduced through extension of coverage.

³ The Crosser Act of 1946 includes benefits for survivors in the railroad plan somewhat along the lines of those provided in the Social Security Act.

⁴ At present the primary benefit (i. e., the benefit to which the wage earner would be entitled and of which other benefits are fractions or multiples) is calculated by taking 40 percent of the average monthly wage up to \$50, adding 10 percent of any average monthly wage in excess of \$50 but not of \$250, and increasing the result by 1 percent for each year in which the wage earner received at least \$200 in wages. If less than \$10, the primary benefit is to be taken as \$10.

CHAPTER III. COVERAGE OF MILITARY SERVICE AND ADJUSTMENT OF DUPLICATE BENEFITS

P. 59
to 76

This chapter discusses a special area of coverage which could have formed part of the preceding chapter, military service being a form of Federal employment analogous in many ways to civil service. However, it was accorded special treatment as being at the time (1945)⁵ much in the foreground of public attention.

It deals with—

1. The benefit rights of persons with military service under existing law and under proposed changes; the extent to which such rights are reduced or lost because of military service, and the effects of two classes of pending bills which would recognize military service by way of "freezing" or "crediting" it for purposes of insured status and average wages; the principal considerations as to retroactive and prospective coverage of military service.

2. Proposals for adjusting benefits simultaneously received under two or more public plans, in particular under OASI and veterans' legislation.

3. Financing OASI credits for military service.

The discussion is specialized and somewhat technical. The principal conclusion is that an over-all equitable solution must be tied in with universal OASI coverage.

CHAPTER IV. LIBERALIZING OLD-AGE AND SURVIVORS INSURANCE PROTECTION

P. 72
to 102

This chapter considers liberalization in respect of two distinct though interrelated aspects:

A. Liberalizing the benefit schedule.

B. Including the hazard of extended disability.

ADJUSTMENT OF EXISTING OASI BENEFIT AMOUNTS

P. 91
to 92

Considerations brought out by discussion under this heading include the following:

1. Any benefit liberalization involves long-range commitments, since benefits are based on average wages over a period of years and so lag considerably behind changes in the wage level.

2. Liberalization of the present formula should be cautiously approached due to the uncertainty of future wage and living-cost levels.

3. Extension of coverage would in itself increase many benefits by removing the depressing effect of limited coverage on average wages.

4. Benefits should be liberalized only with the entire prospective program in mind; it is now quite uncertain whether or not disability benefits or general medical care will soon be included in the system.

⁵ Since then the problem has been in a measure temporarily solved by inclusion in the 1946 amendments of special provisions for granting insured status to World War II veterans for 3 years after discharge. This temporary protection is for survivor benefits only.

5. Liberalizing benefits based on low wages is much the most important aspect of liberalization from the standpoint of lowering costs of old-age assistance and aid to dependent children.

6. Any change which would pay about as large benefits to intermittently covered as to continuously covered workers (as by liberalizing the definition of "average wage") would increase the burden on other contributors or the general taxpayer; it would therefore require strong social justification (extension of coverage would seem to be a more important approach to intermittent coverage).

7. Benefit increases should depend primarily on the extent to which they are found necessary to accomplish the primary purpose of affording basic social protection.

Adequacy of present benefits

The basic pattern of OASI benefits is determined by the individual wage earner's prior wages in covered employment and bears little relation to the cost of subsistence.

P. 77
to 83

The mass of OASI recipients consists of persons with some private income or resources, but insufficient to maintain a reasonable standard of living when wages cease because of death or retirement. Persons without any resources and those with enough to live comfortably even though wages have ceased constitute relatively small groups. The first group is therefore the one most affected by the size of OASI benefit payments. Liberalizing the benefits of this group will not normally determine whether or not they will become public assistance charges, though it will have a considerable effect on their standard of living after retirement.

The relative sizes of these groups is conjectural and will vary greatly with economic conditions. Section D of the appendix to part I (pp. 267-271) gives such organized data as was available as to sources of support of persons aged 65 and over.

The effect of benefit liberalization on public assistance would be considerable. Even minimum benefits of \$15 or \$20 a month to an old couple or to a widow and orphans may relieve them of the necessity to seek assistance and so to undergo a means test. Even if there are no other resources, need (and therefore the cost of necessary public assistance) will be reduced where OASI benefits are payable.

The question of redefining average wage so that absence from covered employment would not reduce average wage and benefits is discussed on pages 85-88 in relation to the principal causes of absence, viz:

1. Inability to find work.
2. Inability to work because of disability.
3. In the case of women—marriage.
4. Work in employment excluded from OASI.

Principal considerations in regard to a redistribution of benefits over the years are—

1. Equity as between short-time and long-time contributors.

2. Whether the future, like the past, will be marked by long-range increases in wages and living costs.

Possible adjustment techniques are—

1. Reducing the rate of future increment⁶ while increasing early benefits.

2. Placing a maximum on future increment.

The view is taken in the report that the question of modifying benefits, e. g., to effect future reductions so as to offset present increases, is a matter of judgment rather than of technique—that once objectives are settled a formula can be devised to attain them.

Figures are given on page 89 to illustrate:

1. The tendency of OASI benefits to change more slowly than current wage levels.

2. The difficulty of evaluating their adequacy in terms merely of percentages of current wage level or living costs.

3. Their inadequacy in comparison with 1940, if price and wage levels substantially in excess of 1940 can be assumed.

Liberalizing the benefit formula

Minimum or near-minimum benefits, the most important ones from the viewpoint of an alternative to public assistance, are generally payable because covered employment was only occasional. The philosophical question then arises as to whether the recipient is fortunate to receive anything at all, or whether his case illustrates a situation that calls for correction. This may take the form of (1) extension of coverage, (2) modifying the policy that led to the establishment of a minimum through requiring its substantial increase.

It is possible to change minimum benefits considerably without affecting the main part of the benefit formula. Three methods of accomplishing this are discussed on pages 83 (bottom) and 84.

Suggestions for over-all liberalization of the benefit formula include:

1. Changing the present \$10 minimum to \$20.

2. Changing the present \$50 of average-wage breaking-point in the formula to \$75.

3. Extending the present formula from \$250 a month average wages to \$300 a month.

Of these, the third is perhaps the only one that, in terms of pay roll, would tend to reduce rather than increase costs. Also by taking monthly wages up to \$300 into account a wider range of benefits would be possible.

The first two tables on page 85 indicate differences in benefits as between the present formula and one incorporating the above changes.

The present general relationships between wages, contributions, length of time in the system and benefit amounts are illustrated by the table on page 83. (The figures for

P. 83
to 91

⁶ In the present formula the term "increment" denotes the 1-percent increase in the basic primary benefit for each year in which covered wages reach \$200.

total wages, which are set down in units of \$100, also represent dollars of contribution at a 1-percent rate.) Relationships of this type are pertinent to liberalization of benefits, whether by way of changing the minimum or the general formula.

It is to be noted that—

1. The proposed new formula is of the same general nature as the existing formula, and in the case of further wage increases its revision would no doubt be sought for the same reasons that the earlier revision was sought.

2. The selection of any particular pattern geared to average wages will of necessity, if its appropriateness is related to a particular economic situation, become inappropriate when the situation greatly changes.

INCLUSION OF EXTENDED DISABILITY BENEFITS

P. 92
to 95

The section on extended disability benefits discusses inclusion of the hazard of extended disability, with the same benefit formula as OASI, and independently of any medical care or temporary disability program, from the viewpoints of:

1. Nature, feasibility, and cost of the provision to be adopted.

2. Relative effects of a program applicable to disabled adults without regard to age and, as a transitional measure, one limited to disability at advanced ages.

Emphasis is laid on the "wide uncertainty attaching to disability costs," involving a fivefold "reasonable (not limiting)" range of from 0.5 percent to 2.5 percent of pay roll. The factors that determine disability costs are discussed under the headings of:

1. Definition of disability.
2. Administrative methods and effectiveness.
3. Current economic conditions.

Three approaches to a definition—physical, occupational, and general—are considered, the weight to be given to each depending on "the nature and underlying philosophy of the particular plan," though "general" incapacity for any sort of work is indicated as "the concept most suited to a social plan of extended disability benefits."

It is pointed out that, in a plan using the OASI benefit formula, very complicated rules would be required for determining a minimum proportion of earning power that must be lost for a claimant to qualify for benefit; and that the alternative would be to leave to administrative discretion the determination of whether or not loss of earnings and of earning power are sufficient to warrant payment of benefits.

The importance of rehabilitative measures and encouragement of self-help, particularly for younger persons, is stressed.

It is pointed out that a disability scheme, like the existing retirement provisions, is necessarily to some extent an adjunct to the economic system, supplying it with, or relieving it of, marginal labor, according to the state of the labor market. To prevent abuse of this legitimate function whereby the

system might come to be used largely for unemployment benefits, it is proposed that the possibilities of creating a special protected labor market for disabled persons be explored. From it disabled persons would be encouraged to graduate to the open labor market as soon as desirable, while the requirement of entering it would be a test of the bona fides of the claimant and a screen for the system against malingerers.

A suggested initial step

P. 101

A proposal is explored for making extended disability benefits available, at least initially, only to persons above some specified age like 55 or 60. This would be largely equivalent to a flexible retirement age, based on a physical—perhaps also an economic—test of the need to retire short of 65.

Some advantages claimed for this approach are—

1. Avoidance of some of the major administrative problems largely associated with disability at the younger ages.
2. Minimizing the cost of doubtful awards by curtailing the possible compensable period.
3. Eliminating classes of doubtful claims by persons already voluntarily withdrawn from the labor market with no present intention of returning.
4. Relieving pressure to reduce the retirement age, chiefly for women, and particularly when economic conditions are bad.
5. Making benefits available for the very considerable proportion of persons with sufficient disability to retire before age 65.
6. Operating to conserve, through the freezing of insured status, an old-age benefit for some who might otherwise lose their insured status.
7. Diminishing the need for rehabilitation in connection with the plan.

Some disadvantages claimed are—

1. Failure to cover a large part of disability—particularly in an area where the consequences of disability for the individual can be most serious, viz the age groups in which dependent children are most numerous, and where the need for protection lasts longest.
2. Tendency to regard as permanent any disability coming within this limited scheme.
3. Difficulty, in a scheme covering only older groups, of placing primary emphasis on recovery and return to work.
4. Reducing, even for these groups, the social value of the scheme through stringent eligibility tests, with emphasis on permanence of disability.
5. Discriminating between the old and the young in regard to eligibility for disability benefits and the effect of periods of disability on insured status for, and the benefit level of, later death or retirement benefit.

6. Establishment of many intricate procedures incident to administering a disability program, while excluding at least temporarily a large proportion of disabled cases solely on the basis of age.

The suggestion is thus quite controversial, but would seem to offer a promising method of "easing in" to a disability program, if such a program has been decided on, with a minimum of initial difficulty, while acquiring valuable experience on which future extensions can be based as and when they appear feasible.

CHAPTER V. FINANCING OLD-AGE AND SURVIVORS INSURANCE

P. 103
to 121

This chapter discusses the principal considerations involved in fixing a schedule of taxes for OASI (under the Federal Insurance Contributions Act). These are of two types:

(a) Actuarial—largely estimating (1) prospective benefit outlays (2) the returns to be expected from the pay-roll tax at various rates. The validity and limitations of these estimates are discussed.

(b) Determining tax policy.

ACTUARIAL ASPECTS

The Social Security Board's efforts, both short and long range, to weigh the costs of future benefits are reviewed, and the following conclusions drawn:

1. That these calculations have been made conscientiously and with a great deal of care as to detail. They show that well-equipped workers have given thoughtful consideration to the statistical problems involved. The reports show every evidence of thorough, honest, and disinterested efforts to elucidate a highly technical problem.

P. 109

2. That the very limited statistical basis available made estimates difficult and brought into question the reliability of this basis as guidance to the future.

3. That because substantially different sets of fundamental assumptions gave equal prospect of being verified it was deemed wise to show results of two or more sets and to note how changes in assumptions would affect cost figures.

4. That all calculations verify the somewhat obvious expectation that the total of benefits will come to be many times as large in later years as at present—both because the proportion of the people past age 65 will be much greater than today, and because a rapidly increasing proportion of them will be eligible for retirement benefits.

5. That while different sets of realistic assumptions may result in cost figures which vary in the course of years by as much as 100 percent the variation as percentage of pay rolls is apt to be much smaller.

6. That in the absence of any conviction that future years will follow the limited statistical guides now available, it would be fruitless to make additional independent estimates of cost because they would necessarily rest on sets of assumptions at least as arbitrary as those already used. There could be no more assurance that any such independent estimates would be verified by experience than that this or that estimate already examined will prove accurate.

TAX POLICY

The principal considerations involved in fixing a tax schedule are— P. 112

1. Lack of confidence in any conclusions based on estimates that reach many years in the future, other than the broad expectation that the cost of benefits will, in the course of years, increase fairly gradually to many times its present size (though with irregularities, now unpredictable, in size and timing).

2. Desirability that pay-roll taxes (i) pay a substantial part of the cost, (ii) contemplate only scheduled changes in tax rate—at regular intervals and smoothly graded, (iii) build up only a modest contingency reserve.

3. Desirability of support from revenue when for a particular year benefits exceed taxes and interest on reserve (the excess, perhaps, to be shared by the contingency reserve and general revenue).

4. Value in Congress accepting a policy that it might hope to follow for a good many years. There can be overemphasis on possible harmful effects of (i) further growth of the trust fund (ii) failure to increase the tax rate according to a previously adopted schedule.

5. Probable greater acceptability among the American people of a growing trust fund rather than an unscheduled increase in tax during a period of depression (though, during a period of totally unexpected low benefit while the plan was getting under way, a "frozen" tax rate has probably been more acceptable to them than would have been a still more rapidly growing reserve fund).

6. Unlikelihood of dire consequences from either a modest increase in tax rate or continuation for a while of the present rate.

With these considerations in mind the report suggested, in respect of OASI benefits as at present, but with the expectation that the coverage will be widely extended: P. 121

1. That tax rates on employer and employee alike be increased one-half of 1 percent every 10 years, beginning with 1947, until a 3-percent rate is reached in 1977.⁷

2. That a Federal subsidy be anticipated to meet any future year's excess of benefit and expense payments

⁷ The 1947 amendments hold the rates at 1 percent each through 1949 with a ½-percent increase for 1950 and 1951 and a further ½-percent increase thereafter, i. e., rates of 2 percent each for 1952 and subsequent years.

over social security taxes and interest on the trust fund, until such time as this subsidy becomes a third of the year's total of benefit and expense payments. When this stage appears imminent revision of the tax schedule should be considered, as also when the trust fund reaches some set total like 20 billion or 30 billion dollars.

The table on page 121 illustrates the possible courses of the trust fund under typically "low" and "high" assumptions if this schedule of taxes is followed. It will be seen that the estimates vary widely with the assumptions.

CHOOSING A METHOD OF FINANCING

In choosing a method of financing two extreme positions may be taken:

P. 110
to 114

1. Paying each year's bill as it comes along, with no thought of the future.
2. Trying to budget in such a way that the burden is about the same year by year. The latter, of course, means larger initial contributions than are needed for current outlays, and their accumulation in the hope of lightening the load in future years. Between these extremes are innumerable variations according to the degree in which current contributions exceed current outlays. It is from this array of methods that Congress must choose.

In making its choice Congress must determine (1) the relative roles of pay-roll taxes and of general taxation in financing benefits, (2) the particular tax schedule to be adopted. These decisions will doubtless reflect convictions regarding the building of reserves in early years through pay-roll taxes in excess of current benefits, and attention to the purpose and history of the system.

The report lays down three major tests for a desirable plan of financing:

1. High promise of being followed for a long time so that benefits will be paid as contemplated (feasibility test).
2. Generally acceptable as reasonable, equitable and not unduly burdensome (popularity test).
3. Confining its objectives as much as possible to financing social benefits and avoiding harmful interrelationships with other phases of the national economy (economic effects test).

These three tests are respectively applied to (1) the tax schedule as then (1945) embodied in the law and (2) the pay-as-you-go plan (contributions to follow benefits). See pages 114 to 118 of the report.

Some significant conclusions are:

1. Where substantial reserves are involved, continual educational efforts will be needed to keep people sufficiently informed to realize that no bad faith is necessarily involved when social-security taxes in excess of current requirements for benefits and administration are replaced

by interest-bearing promises to pay, and the money used to meet the expenses of government. For example, the Government securities issued to the social-security-trust fund may mean that the amount thereof is offset by a corresponding reduction in either new borrowings on the open market or in outstanding Government securities held by other parties.

2. The reserve issue boils down to the question of whether it is good policy to use a regressive tax (on the first \$3,000 a year of wages) to reduce the public debt or even to increase our national supply of durable goods, if such increase actually takes place.

3. The pay-as-you-go method would meet the tests of feasibility and popularity if the Government comes into the picture to the extent necessary to hold wage taxes to a predetermined smooth course and to keep them from ultimately becoming very high.

4. Pay-as-you-go would no doubt be less disturbing to the general economy than if substantial reserves were being built up.

TENDENCY TO LIBERALIZE BENEFITS

There is continuous pressure in this direction motivated by—

P. 118
to 119

1. Agreement that benefits are quite modest and must often be substantially supplemented to meet even minimum subsistence needs.

2. Their increasing illiberality in terms of wage levels and living costs.

However, there is danger in liberalization due to:

1. The fact that costs will be very much heavier in future years even without any change in the benefit formula.

2. The tenuous nature of the line between those who receive benefits and others quite similarly situated who fail to qualify.

3. Even if OASI benefits applied to everyone, there are additional kinds of social services that are equally justifiable on a Nation-wide scale. Pending exploration of needs not now being filled, we should curb our enthusiasm to make OASI benefits larger for each individual, lest we go so far with our first choice of social benefits as to be unable to make headway in other lines of equal social promise.

With this common ground two opposing contentions are advanced with much vigor, conviction, and emotion by well-informed students, and each group can cite undoubtedly authentic historical incidents in their support:

(a) Those who favor higher taxes and the consequent substantial reserve contend that, unless taxes are raised soon, it will be impossible to withstand the pressure for increased benefits; while

(b) Those who favor pay-as-you-go contend that, just as surely as the reserve fund gets much larger, the popular cry

will be that this accumulation of excess social security taxes is the best evidence that benefits can be safely liberalized, and that any increase in taxes will be the signal for petitions to increase benefits.

It seems, therefore—

1. That our protection against the danger of over-liberalization had better not rest on the theory of one or the other of these groups, but rather on the firmness of an informed Congress.

2. That decisions as to methods of financing had better rest on other grounds than making it easy for legislators to resist undue pressures.

CHAPTER VI. MISCELLANEOUS

P. 125
to 148

This chapter deals with six not necessarily interrelated subjects.

BENEFIT RIGHTS OF NEW ENTRANTS INTO OASI

P. 125
to 129

The eligibility requirements and benefit formula of the present limited coverage system were designed to screen out many cases with little or no coverage and to pay small benefits to border-line cases. This limit on the social protection of the system was considered a necessary financial safeguard. The present question is the extent to which the need for social protection of aged new entrants and others with limited coverage justifies scrapping the existing OASI safeguards if such need does not also warrant extending coverage and eliminating the importance of such safeguards. This issue can be eliminated only if coverage is widely extended.

ELECTIVE OASI COVERAGE

P. 129
to 131

Voluntary coverage cannot be expected to solve the social problems for which OASI was created or to serve as an effective substitute for compulsory coverage. Moreover, it has serious implications for OASI in that (1) it implies contractual rights which are foreign to OASI, but will be brought up as arguments against any changes in the system that may be adverse to particular interests (2) there would be continuous selection against the system which would operate to defeat its social objectives.

VOLUNTARY ANNUITIES

P. 131
to 140

Sale of annuities by the United States Government to the public on a voluntary basis is sometimes advocated, generally with the express or implied purpose of making available to those lacking OASI coverage, or whose benefits will be small, a means of providing for their old age. It is generally assumed that the annuities will be of small amount—not more than \$1,200 a year—that their sale will not therefore encroach on private annuity business, and that the cost will be materially below that of private annuities. However,

investigation of experience both here and abroad makes it clear—

1. That this approach to the problem of dependency is likely to fall far short of its mark, and indeed is apt to miscarry through being taken advantage of mainly by persons other than those for whom it is primarily intended.

2. That the ability of Government to sell such annuities at premiums materially below those of the companies is likely to be realized only with the aid of substantial subsidies, direct or indirect.

3. That the alleged lack of interest of insurance companies in "small" annuities is contrary to fact.

THE "RETIREMENT"⁸ REQUIREMENTS FOR OASI BENEFITS

P. 140
to 145

The requirement that an employee retire before he can draw benefits is discussed in relation to its practical effects on OASI recipients, on the labor market and on the OASI trust fund (pp. 141–143 of the report). Methods of modifying the present requirement are discussed on pages 143–144.

The following suggestions are offered for consideration:

1. Raise the present \$15 wage limitation to, say, \$25 or \$30.

2. If self-employment is included, and perhaps even if it is not included, limit annual permissible earnings to 12 times the earnings permissible in 1 month.

3. Limit the effect on benefits of exceeding the permissible monthly or annual earnings to a reduction of no more than the excess.

4. Eliminate the retirement requirement entirely for those well past 65, for example, 70 or older.

The last of these is a radical departure which should make OASI more attractive to—

1. The self-employed, who will tend to pay more OASI taxes while drawing less benefits.

2. Those gainfully employed who do not contemplate giving up work entirely.

If this suggestion is adopted along with disability, the OASI system could be described as providing benefits—

1. Before 65 when a person cannot work;

2. From 65 to 70 when he does not work; and

3. From 70 on under all circumstances.

REDUCING OASI AGE REQUIREMENT FOR WOMEN

P. 145
to 146

This section is mainly a summary of the reasons which have been advanced for the reduction in the retirement age for women from 65 to 60. Such a change also contemplates the reduction to age 60 of the age requirement for old age benefits in the case of qualified wives and widows.

⁸ In OASI, retirement has the special meaning of not earning in any month \$15 or more in employment covered by the act. The retired individual is entirely free to earn whatever he can in noncovered employment.

THE THREE-TIMES RULE IN FINANCING OASI

P. 146
to 148

The tenor of this discussion is the inappropriateness of continuing to use as a criterion of whether or not pay-roll taxes should be increased at any time a tentative and empirical rule the original purpose of which has been misunderstood, and which in any case was based on forecasts that events have rendered no longer valid.

The percent of pay-roll costs in table II on page 148 are of some interest, aside from operation of the three-times rule, as indicating costs that could eventually develop under the present program.

REVIEW OF APPENDIX TO PART I

P. 148
to 274

Section A. Reproduces the Social Security Board's then most recent OASI Actuarial Cost Studies, viz, No. 19, Level Wage; No. 19 (a), Increasing Wage; and No. 19 (b), Disability.

Section B. A technical detailed analysis of the involved processes underlying the long-range cost estimates in Actuarial Study No. 19 of existing OASI provisions. Includes an array of 50 interrelated tables arranged, as nearly as possible, in logical sequence, with explanatory text proceeding more or less in reverse direction to the tables, i. e., from end results back to basic data and assumptions. Though not so stated in the report, it may be noted that perhaps the chief value of this analysis lies in the feeling it gives of the tremendous complications necessarily involved in any attempt to develop OASI cost estimates, due to the many social, demographic, economic, and other factors that must be considered; of the limitations and uncertainties attaching to the results obtained; of the reservations with which they must be accepted and the caution with which they must be used.

The material and techniques involved are undergoing a continuous evolution under the impact of experience and further research, and the Social Security Administration has since produced revised estimates.

Section C. Furnishes reference material on the coverage of military service and adjustment of duplicate benefits.

Section D. Presents in three tables results of some (unofficial) Social Security Board studies depicting the relative importance of the chief sources of support of the aged. No objective accuracy is claimed for these tables.

Section E. A brief review of then (1945) existing retirement-income provisions (chiefly employer-employee plans) that are not part of the social-security legislation but may be regarded as either actually or potentially supplementary to OASI—whether or not specifically designed to serve such purpose.

PART II. PUBLIC ASSISTANCE

PREPARED BY

DONALD S. HOWARD

Director of Social Work Administration
Russell Sage Foundation

NOTE.—The text presented in this part is in the exact language used in Issues in Social Security except in the case of interpolated material indicated by brackets as follows: []. The 1946 amendments to titles I, IV, and X which were enacted subsequent to the publication of Issues in Social Security render many sections of that report obsolete. No indication is given of the omission of words or paragraphs included in the original but not repeated here.

PART II. PUBLIC ASSISTANCE

INTRODUCTION

The principal problems which have arisen in the Federal-State programs of public assistance for needy individuals [include]— P. 275

(1) Limitations under Federal law [upon] meeting needs which exceed maximums that will be matched [from Federal funds], the disparity among States in the levels of public assistance payments; and

(2) [Limitation] of Federal financial participation to selected groups of needy persons.

Under titles I, IV, and X of the Social Security Act the Federal Government provides for matching money payments to needy persons under approved State plans for (1) old-age assistance, (2) aid to dependent children, and (3) aid to the blind.¹ [These three programs are known as special-assistance programs to distinguish them from the general assistance programs of State and local governments, which without benefit of Federal aid, are intended to meet needs not covered by the Federal-State measures.]

Provisions in the [Social Security Act] in no wise prevent the States or localities from establishing assistance programs on a broader base of coverage or with more liberal grants to individuals. There is a tendency, however, for States to organize their programs in such a way as to obtain the most funds in Federal matching for a given State expenditure. States which have established programs broader than the Federal provisions for matching often feel that the unmatched portion of their expenditures should receive like Federal consideration. In States which have limited their programs to the Federal provisions for matching, some needy persons inevitably receive no care or inadequate care. P. 275

EXPERIENCE SINCE 1935 IN THE SPECIAL TYPES OF PUBLIC ASSISTANCE P. 328

The establishment with Federal participation of State programs of old-age assistance, aid to dependent children, and aid to the blind has been a gradual process. Yearly since 1935 when the Social Security Act was enacted, new State-Federal programs have been inaugurated. Now, State-Federal programs of old-age assistance are being administered in all 48 States, the District of Columbia, Alaska, and Hawaii. Of these 51 jurisdictions, all but 1 (Nevada) has a

¹ Pertinent sections of the Social Security Act are summarized on pp. 325-327 of Issues in Social Security. These do not, of course, show changes effected by the 1946 amendments which were enacted after the Report was issued.

State-Federal program of aid to dependent children, and all but 4 (Alaska, Missouri, Nevada, and Pennsylvania) have State-Federal programs of aid to the blind.² Thus, the public assistance provisions of the Social Security Act are in effect on substantially a Nation-wide scale.

Persons receiving aid

In the United States in [June 1947, approximately 2,271,000 persons were receiving old-age assistance; 396,000 families containing more than a million children were receiving aid to dependent children; and 79,000 persons were receiving aid to the blind. For the country as a whole, 214 out of every 1,000 persons 65 years of age and over received old-age assistance. Of every 1,000 children under 18 years of age, 23 received aid to dependent children. Of every 100 persons estimated to be blind, 27 were receiving aid to the blind.] P. 328

Trend in load.—From 1936 until 1942, when wartime demands for labor became acute, the number of recipients of each type of aid rose steadily. During the war the number of recipients of old-age assistance and aid to dependent children declined substantially. Declines occurred also in established programs of aid to the blind, though these declines are obscured by the inauguration in 1943 of a new State-Federal program of aid to the blind in Illinois. P. 332

The continuous decreases in the number of persons and families receiving assistance during the war years when the employment market offered job opportunities to persons not normally employed or employable is evidence of the essential flexibility of assistance programs. The sharp reductions in assistance rolls demonstrate also that needy persons prefer self-support to dependency. [Since the war assistance rolls have again begun to rise. Numbers aided under the various assistance programs for 1944 to 1947 are presented in table 1, page 46 of this digest.]

Payments to recipients

[In June 1947, payments of old-age assistance in the United States totaled approximately 82 million dollars. In States administering programs under the act, payments of aid to the blind were about 2.4 million dollars and of aid to dependent children, 24 million dollars. The average old-age assistance payment was \$36.04, and of aid to the blind, \$37.87. Payments of aid to dependent children averaged \$61.68 per family.] P. 332

Trend in average payments.—Over the years, levels of assistance have risen substantially [table 2, page 46 of this digest]. The rise in average payments represents in part an increase in the amounts allowed to meet the rising cost of such requirements as food, shelter, and clothing, in part to the recognition of a wider range of requirements and in part to the withdrawal of certain supplementary assistance formerly available to recipients; namely, surplus commodities and surplus food stamps. In some cases, categorical P. 333

² Detailed description of the operation of these programs is presented on pp. 328-336 of Issues in Social Security.

payments now include amounts formerly provided from general assistance to supplement the categorical payment. Average payments for the Nation fail to reveal the variations among States in levels of payments [discussed under "Average State Payments, page 30 of this digest"].

Fiscal arrangements

P. 333

Source of funds.—All States claiming Federal funds must provide for State financial participation in the costs of the special types of public assistance. Whether the State will bear the entire non-Federal share or will require some local financial participation is determined by the State. Patterns of State-local financial participation in the special types of public assistance, therefore, vary from State to State and often differ among programs within a State.

[According to the report (p. 334) 15 States³ in 1944 required local financial participation in all three special assistance programs; 8 (Colorado, Indiana, Iowa, Massachusetts, Minnesota, North Dakota, Ohio, and Wyoming) required local funds for two of the three programs, and 5 States (Connecticut, Delaware, Maine, New Hampshire, and Vermont) for one program. The remaining 20 States with approved plans required no local funds.

[The proportion of assistance expenditures in 1944 met from Federal, State, and local funds respectively in the several States is presented in table 9 on pages 343-344 of the report.

[The degree of Federal, State, and local financial participation is not uniform as between one public assistance program and another. In 1944, for example, Federal funds amounted to approximately 48 percent of all expenditures for old-age assistance payments, 47 percent of all payments for aid to the blind, and 36 percent of payments for aid to dependent children. In all instances these proportions were higher than during the earlier years of the Federal-State programs.

[These changes in terms of both percentages and dollars and from 1936 to 1944 are presented in tables 5, 6, 7, and 8 on pages 340-342 of the report.

[Not since 1936 has the Federal Government contributed toward general assistance costs.

[The relationship between income payments and amounts spent in the various States for special assistance and for general assistance in 1944 is presented graphically in chart 4 on page 291 of the report.]

CURRENT PROVISIONS FOR NEEDY PERSONS NOT COVERED BY THE SOCIAL SECURITY ACT

In most parts of the country, persons who are not eligible for special types of public assistance have less assurance of receiving adequate aid—or any aid—than the groups of needy persons for whom Federal funds are available. For

P. 297

³ Alabama, California, Georgia, Kansas, Maryland, Montana, New Jersey, Nevada, New York, North Carolina, Oregon, Tennessee, Utah, Virginia, and Wisconsin.

the sake of convenience, all local forms of home relief to these uncovered persons has been termed "general assistance." The major reasons for the unevenness of general assistance lie in the administrative and financial pattern for aiding this residual group.

Organization, supervision, and financing

General assistance is administered in the United States by more than 10,000 local units—counties, villages, and towns. P. 297

In over two-thirds of the States with State agencies having some responsibility for general assistance the degree of State leadership ranges from practically no participation in the policies and practices of the local units to administration by State agencies through branch offices in the counties. It is only natural that eligibility and amount of assistance should vary with each independent administrative unit.⁴

In 1944, 14 States assumed no financial responsibility for general assistance and 3 other States contributed less than 3 percent of the cost. In the country as a whole in 1944 local funds [totaling \$48,000,000] met only 7 percent of the cost of old-age assistance, about [13] percent [representing a total of 2.5 million dollars] of the costs of aid to the blind, and about [17] percent [\$23,000,000] of the costs of aid to dependent children. For general assistance however, the local share [\$46,000,000] was 52 percent [of the total]. P. 298

Except in large metropolitan areas and in wealthy residential communities, the limited revenue sources available to counties, cities, or towns sharply restrict the funds that localities can muster for general assistance. In States with relatively low fiscal ability, the opportunity to receive matching Federal funds for the special types of public assistance has tended to limit—rather than to increase—State and local funds for general assistance. Since each State-local dollar spent for the special types of assistance—up to the matching ceilings—draws to it a Federal dollar, States have tended to use their available funds for the federally matched programs. As long as the general-assistance program remains outside the scope of Federal grants-in-aid, it will be at a financial disadvantage. P. 298

The imbalance between expenditures for the special types of public assistance and for general assistance is illustrated by comparing expenditures for the programs per capita of the State population. One-fourth of the States [in 1944] spent more than 20 times as much per inhabitant for the special types of public assistance as for general assistance; 2 States spent over 100 times as much. These differences far exceed what normally would be anticipated from known facts on differences in need in the various population groups.⁵ P. 299

⁴ Detailed description of the administration of general assistance is presented on pp. 289-301 and on pp. 348-349 of *Issues in Social Security*.

⁵ For detailed State data see table 15, p. 348 of *Issues in Social Security*.

Extent and amount of general assistance

During the war years, relatively few people needed general assistance. In August 1945, 230,000 cases, representing approximately 420,000 persons, received [this type of aid]. The number of cases aided in June 1947 was 335,000. The general trend in the number granted general assistance between 1944 and 1947 is presented in table 1, page 46 of this digest.

[In proportion to population, the numbers of cases granted general assistance in the various States show very great disparities. In June 1947, for example, general assistance was granted to 923 cases per 100,000 population in Maryland, while in Mississippi the rate was only 35 cases per 100,000 population. By contrast, the incidence of special assistance—with the benefit of Federal and State financial participation—in the various States showed less disparities than did the incidence of general assistance. The incidence of general assistance in the State having the highest rate was 26 times that in the State with the lowest rate, although the highest rates for old-age assistance, aid to the blind, and aid to dependent children were only about 11 times the lowest State rates. Comparisons of all rates in the various States are present in table 3, page 47 of this digest.]

The average payment for general assistance in the United States in June 1945 was \$29 per case for the month. Averages ranged from \$45 per case in New York to \$9 in Mississippi. [In June 1947 payments averaged \$39.18, ranging from \$65.55 in New York to only \$10.12 in Mississippi. Averages for all States are presented in table 4, page 48 of this digest.]

In many States, standards of general assistance are substantially lower than those of the special types of public assistance. Sometimes the amounts allowed for certain requirements are smaller, the range of recognized requirements is narrower, evaluation of resources is more restrictive, and larger cuts in payments are made from the amount of established need when funds are insufficient.

[When general assistance payments for the country as a whole averaged \$39.18 per case (in June 1947) old-age assistance payments per individual⁶ averaged \$36.04. However, in 30 of the 44 States for which comparable data are available, old-age assistance payments per individual⁶ averaged more than did general assistance payments per case.⁷

[General assistance payments in 1946 totaled approximately \$121,000,000. This was only slightly more than a quarter of the total general assistance payments in 1936 and only about 8 percent of the depression peak of 1935 when the Federal work program was not yet under way.]

⁶ Old-age assistance payments, though usually made to individuals, occasionally include provision for the needs of more than 1 person.

⁷ By "case" is meant a unit ranging from a single individual to a family with, perhaps, a number of children. In August 1945 (see p. 299 of *Issues in Social Security*) general assistance cases included an average of 1.8 persons per case. The proportion of single individuals among general assistance cases varies widely from State to State. In June 1945, when 1 person cases represented about 64 percent of all general assistance cases in the United States, the proportion ranged from less than 50 percent in Indiana and Missouri to more than 80 percent in Pennsylvania and South Carolina, the District of Columbia, Alaska, and Hawaii (see *Issues in Social Security*, p. 349).

A. MORE ADEQUATE AID

States tend to limit [special] assistance payments to amounts matchable from Federal funds, but those that do not so limit them feel that Federal matching should be extended to their more liberal grants. On the other hand, some States, usually because of limited funds, restrict assistance payments to amounts below need for assistance even though higher payments would be matchable. P. 276

[Since Issues in Social Security appeared the maximums matchable from Federal funds were raised by the 1946 amendments from \$40 to \$45 a month for a recipient of old-age assistance or aid to the blind. In the case of aid to dependent children, the maximums were raised from \$18 to \$24 a month for the first child in a family and from \$12 to \$15 for each additional child aided. Many States still exceed these limits, however, and, as before, believe the Federal Government should participate. The Federal share in old-age assistance and aid to the blind is two-thirds of the first \$15 of the average payment and one-half the balance of matchable payments, and in aid to dependent children, two-thirds of the first \$9 per child plus one-half of the balance of matchable payments.]

The size of a recipient's monthly payment and the Federal contribution to it varies almost as much because of differences in State standards [and available funds] as because of differences in the amount of need. This State-to-State variance is substantially greater than is justified by difference in cost of living.⁸

AVERAGE STATE PAYMENTS

[Although the 1946 amendments were intended in part to reduce the disparities in payments made by the various States, these have, nevertheless, remained considerable. Old-age-assistance payments, which in June 1947 averaged \$36.04, ranged from \$65.11 in Colorado to only \$15.09 in West Virginia; aid-to-the-blind payments ranged from \$62.84 in California to \$18.05 in West Virginia; and family payments under aid to dependent children ranged from \$105 in Washington to \$24.43 in Mississippi. The average payments made under the assistance programs of the various States in June 1945 and June 1947 are presented in table 4, page 48 of this digest.]

State differences in levels of payments may be explained by a complex of factors. Most important is the difference in the availability of State and local funds for assistance. Stringency of funds often results in (1) comparatively low standards for determining requirements, (2) relatively restrictive policies for considering income and other resources, and (3) the making of payments amounting to less than 100 percent of need as determined under the prevailing P. 332

⁸ Although written before the 1946 amendments became effective, this statement is undoubtedly still true.

standards. Standards for determining requirements of needy persons reflect State differences not only in fiscal resources but also in modes of living and cost of living. Still other circumstances account in part for the variations in average payments. Though the majority of States impose maximums on payments equal to the amounts of the Federal ceilings for matching, some States have higher or lower maximums, and some have none. In some States, amounts for medical care are included in the money payment; in other States, medical care is provided from general assistance funds, through staff services, or in some other manner. In some States, the needs of the entire family [including a spouse, older children, or other relatives for whom Federal matching is not available] are supplied through [special assistance] whereas in other States such needs are supplied from general assistance funds or not at all.

P. 333

INADEQUACIES OF PRESENT MAXIMUMS

When assistance is limited to the amounts that can be shared equally with the Federal Government, the most needy recipients bear the burden in terms of inadequate assistance.⁹

P. 278

[Agency standards frequently allow needy persons more than the Federal maximums, and, some States make payments in excess of the Federal maximums in a considerable number of cases.

[The maximum payments in effect when Issues in Social Security was written were shown by the report to have been inadequate for many recipients. Even after the 1946 amendments, data for January 1947 indicate that no fewer than 20 percent of old-age assistance recipients, 21 percent of aid to the blind recipients, and 49 percent of the families granted aid to dependent children actually received payments in excess of the Federal maximum limits.]

RELATION OF STATE MAXIMUMS TO FEDERAL MAXIMUMS

By November 1, 1945 [when the Federal maximum for both old-age assistance and aid to the blind was \$40 per recipient], 8 States had maximums above \$40 for old-age assistance, another 6 States permitted higher payments for recipients with special needs, and 12 States had no maximums. For aid to the blind, 4 of the 47 States with State-Federal programs had maximums above \$40, 4 permitted higher payments in special circumstances, and 13 had no maximums. For aid to dependent children, 7 States had maximums higher than the Federal ceilings; 1 of these permitted higher payments if the payment included medical costs, and 26 States had no maximums.

P. 278
to 279

[The increases in the Federal maximums under the 1946 amendments were immediately reflected by similar action on the part of the States. Between September 1946 and Janu-

⁹ See pp. 276 to 282 of Issues in Social Security.

ary 1947 1 State deleted its maximums, 24 States raised their maximums for old-age assistance, 20 States raised those for aid to the blind, and 14 raised those for aid to dependent children.

In aid to dependent children the amount of the Federal maximum is based solely on the needs of the children—the need of the mother is ignored insofar as Federal matching is concerned. Accordingly, in States that deal realistically with the problem, the cost in most cases greatly exceeds the amount the Federal Government will match. The portion of State expenditures under this program matched by Federal funds is much lower than under the other public assistance programs, though care of children is more important to the Nation's future than care of any other group.

P. 304

P. 305

Payments limited to Federal ceilings

Among States which have retained maximums, the present Federal ceilings remain the most common State maximums. Legislatures in some States which limit payments to the Federal ceilings have set their maximums in terms of whatever amount is established by the Federal act. On the other hand, some States that have no legal maximums, because of inadequate appropriations, limit payments by administrative action to the amount subject to full Federal matching.

P. 279

[Assistance] payments [as discussed here] do not include amounts paid by assistance agencies to hospitals and physicians for medical services to recipients, in which Federal funds do not share. In some of the States supplementary payments of general assistance have been made to the families or persons whose minimum needs exceed State [special assistance] maximums. Such expenditures increase still further the disparities between the Federal and the State-local shares.

P. 279
to 280

CHANGING OR REMOVING FEDERAL MAXIMUMS

To encourage States to make payments, when needed, in excess of present maximums, either of two methods might be adopted—the maximums might be removed, or they might be raised or otherwise liberalized.¹⁰

P. 280

Removal of Federal ceilings

Some States have found it feasible to share in payments based on the amount of need determined by local workers without placing arbitrary limits on payments. The same plan applied in the Federal-State partnership would simplify administration, since the Federal Government would then participate in whatever amount the State found necessary for all persons eligible under the Social Security Act.

P. 280

Procedures [established by] assistance agencies for determining the amounts of payments [even in the absence of ceilings of any kind] serve as a continuing control on expend-

¹⁰ Since Issues in Social Security was printed, the then prevailing maximums have, as has already been noted, been slightly increased. The basic problem remains unchanged, however, inasmuch as the small increases in maximums authorized in 1946 still leave many needs unmet.

itures. Payments are based on standards set by the agencies. State and sometimes local responsibility for sharing in the costs of assistance keep standards within the fiscal capacity of the governmental units.

Liberalizing Federal matching provisions

A maximum in terms of an average amount per person aided would provide greater flexibility than the present maximums on individual payments and would be easier to administer. Within the limits imposed by such a maximum, States could use Federal funds as they were needed in meeting the exceptional requirements of some recipients as well as normal needs. The amounts above the average required for some recipients would tend to be balanced by amounts below the average for recipients with lower requirements or other resources. In addition, if parents or persons acting in place of parents were included among the recipients of aid to dependent children in determining average payments to be matched States would be encouraged to make more nearly adequate payments to families receiving this type of assistance.

P. 282

FEDERAL AID FOR MEDICAL CARE

Experience of State agencies suggests that maximums on payments to individuals are a special problem in meeting health requirements of needy individuals. Health care is a common requirement like food, shelter, and clothing. But unlike them, it often involves large expenditures, usually without previous warning.¹¹

P. 283

The need for medical care

According to the National Health Survey of 1934-36, a house-to-house canvass conducted by the United States Public Health Service, 172 out of each 1,000 persons during a 12-month period suffered disabling diseases either acute or chronic.¹² In contrast, families receiving public assistance experienced a disability rate of 234 out of each 1,000 persons. Average duration of disabling illness among the assistance group was 11.9 days as compared to 3.9 days per person in the group with incomes of \$3,000 and over.

P. 283

Adequate medical care may in some instances reduce the duration of assistance. The vision of some of the persons receiving aid to the blind may by proper medical care be conserved, in some instances, or even be restored.

Effect of Federal maximums upon provision for medical care

P. 283

[In States that] limit medical care to those costs which can be met within the maximum payment, the needy persons' requirements may not be met; if, on the other hand, these

¹¹ Details on the medical care programs of various public assistance agencies are presented on pp. 355-356 of *Issues in Social Security*. On pp. 352 to 354 are presented recommendations of various groups as to improving medical care provided under public assistance.

¹² U. S. Public Health Service, *Illness and Medical Care in Relation to Economic Status*, The National Health Survey: 1934-36, Bulletin No. 2, Washington, 1938, as quoted in National Resources Planning Board, *Security Work, and Relief Policies*, Washington 1942, pp. 118-120.

needs are met the burden will be passed on to the doctor, hospital, or other health agency. Most States make some provision for medical care either outside the money payment or in payments larger than those toward which the Federal Government can contribute. These States believe that the Federal Government should share in such assistance costs.

Federal payments are available at present only for those medical costs which can be budgeted to the recipient [of special assistance]. P. 282

Maximums on grants limit the provision of adequate medical care, both because the maximums are low and because most medical needs cannot be planned for in regular budgeting. Although such costs can be estimated and averaged over a period for a group, as an insurance risk, this average cannot be budgeted to an individual, as can be done with the average cost of food or clothing. On the other hand, if the State or local agency budgets medical expenses for an individual at the time they arise, the individual payment may exceed Federal maximums and place a burden for the excess upon the State or local community. If a higher average were matchable with Federal funds, this would encourage States to remove or modify their own maximums and to expand or create medical-care programs. P. 284

Effect of Federal participation only in money payments to individuals

The requirement in the [Social Security Act] that all assistance be cash also limits the provision of adequate medical care. Unlike the provision of food, lodging, and clothing, medical care is usually rendered before payment is made. Further, the cost of a recipient's last illness may not be known until after his death. This can be a sizable problem since in the period of a year 1 old-age-assistance recipient in 14 dies. If the recipient dies before the medical bills are presented they cannot be met through money payments to the recipient. As a result, the cost of this care, if the recipient had no insurance or other estate, must be paid wholly from State or local funds. P. 285

Meeting health requirements

If Federal matching maximums are eliminated or if payments for medical care directly to doctors, hospitals, and other health agencies are exempted from the maximums, States would be encouraged to establish or improve medical-care programs. If Federal maximums are changed to an average-per-case basis, the excess cost of medical care to particular individuals could be spread over the entire group of recipients. If the Social Security Act is amended to adjust the maximums and/or permit matching of payments for medical care made to doctors, hospitals, and other agencies, the States will be encouraged to adopt the most effective type of plans for medical care, within their financial ability.

B. EXTENSION OF AID

P. 295

The assistance programs in which the Federal Government now participates financially are restricted to particular groups. Responsibility for other needy persons rests wholly on the States and localities. In many parts of the country exclusion of these others from the Federal grant-in-aid programs has resulted in relatively small [and in some States no] State appropriations and hence in very uneven local provision for needy people who are not eligible for the federally matched types of public assistance.¹³ In some places such persons can get assistance only on a meager emergency basis, if at all.

P. 296

TYPES OF NEEDY PERSONS NOT CURRENTLY ASSISTED
BY FEDERALLY AIDED PROGRAMS

For the most part these persons are in need for the following reasons:

- (1) Physical or mental handicap or chronic illness.
- (2) Unsuitability for employment because of age or home responsibility.
- (3) Temporary illness of the breadwinner.
- (4) Inability to obtain employment.

As long as suitable work is available, the vast majority of employable persons provide for themselves and their families. At all times [however,] demands for labor are unevenly distributed.

P. 297

Though unemployment insurance is intended to supply income during transitional periods of unemployment, some workers—among them domestic and agricultural workers, the self-employed, and, in many States, workers in small establishments—are not covered by State unemployment insurance laws. Moreover, in abnormal times many insured workers who lose their jobs exhaust their unemployment benefits and require assistance before they obtain a new job.

Need not covered by general assistance

P. 299

Although the varied State-local general assistance programs purport to be the catch-all for needy persons not covered by the special types of public assistance, several types of need remain uncovered by any program. The restrictive nature of general assistance is the result of (1) State laws such as those establishing requirements of residence or settlement, (2) interpretation due to the local autonomy of the majority of general assistance units, and (3) lack of adequate financing.

Restrictive action of laws or administrative regulation regarding residence or settlement vary from State to State and from locality to locality. In general, it may be said, the person who does not "belong" in a community cannot expect

P. 300

¹³ The proportion of general assistance costs in the several States in 1944 met from State and local funds, respectively, is presented on p. 298 of Issues in Social Security. See also table 16 on p. 349.

continued assistance in the community, and may frequently expect to be uprooted from such community and returned to the community where he "belongs" if he needs assistance. It often occurs, because of conflicting State or local laws regarding settlement, that an individual does not legally "belong" anywhere.

Stringency of funds and local interpretations due to the great number of autonomous local units often cause general assistance agencies to impose additional conditions of eligibility. Thus, in some places, general assistance has been denied to various groups regardless of the extent of their need; for example, to childless couples, single persons, employable persons, self-employed persons, and persons with any other income, no matter how insufficient. Standards for determining need vary greatly from place to place. General assistance is extremely meager in some counties and in others is wholly lacking.

P. 301

FEDERAL PARTICIPATION IN AID TO CHILDLESS WIDOWS, THE INFIRM, AND EMPLOYABLE PERSONS UNABLE TO OBTAIN WORK

P. 301

Several suggestions have been advanced for the extension of Federal participation in assistance to needy persons not currently eligible under the public-assistance titles of the Social Security Act. Extension of coverage in varying degrees is possible by (1) liberalizing eligibility under existing titles of the Social Security Act; (a) by removing Federal restrictions, in aid to dependent children, (b) by elimination of allowable State restrictions such as residence requirements, and (c) by adding groups of similar need to existing titles of the act; and (2) by adding another title to the Social Security Act to provide for Federal-State cooperation in assistance to all needy persons not covered by other titles.

A new title to the Social Security Act

A new title to the Social Security Act, according to this proposal, would provide for Federal participation in assistance to all needy persons in States with approved [plans].¹⁴ The general requirements of the act in regard to approval of State plans could be the same as under the other titles, except that if complete coverage is to be assured the title should provide (1) that medical care could be provided by direct payment to doctors, hospitals, and other health agencies for services; (2) that the State plan should not establish any condition of eligibility dependent upon (a) age, (b) employability, or (c) residence and citizenship, and (3) that the State plan should provide for a system of registering and clearing with appropriate public employment services all employable members of assistance cases.

P. 301
to 302

Federal participation in general assistance would in no way conflict with public policy regarding expansion and strength-

P. 302

¹⁴ Present requirements to which State plans must conform are described on p. 306 of Issues in Social Security.

ening of the present social-insurance programs or the development of a health program.

Adjustment of eligibility requirements for aid to dependent children P. 303

Federal participation in general assistance to all needy persons not assisted under the special public-assistance programs would encourage similar State action. With such State action the needs of dependent children not met through aid to dependent children would be provided for under general assistance. Coverage could, of course, also be obtained by amending the present Federal-State programs for dependent children.

Certain dependent children do not receive assistance under title IV of the Social Security Act either because of a limitation in the act, or because of a limitation in the States' plans. Children in whose aid the Federal Government clearly cannot now share include those who (1) are living with persons other than the relatives specified; (2) are aged 16 and 17 and are not attending school; or (3) are in want because of the parent's unemployment or low earnings.

If these needy children are to receive assistance on as favorable a basis as those eligible for aid to dependent children, it will be through extension of State coverage. Experience to date indicates that usually such extension will not be effected without Federal participation in cost.

Aid for needy children not now covered by title IV of the Social Security Act could be provided through establishment of Federal grants to States for general assistance as well as by extension of Federal matching in aid to dependent children. P. 305

If coverage of aid to dependent children were broadened and Federal funds provided for general assistance, a State would have the option of aiding needy families with children under whichever program seemed more suitable. Under either program, the process of determining eligibility could be simple.

STATE RESIDENCE REQUIREMENTS

P. 310

The issue of residence requirements may be described as the issue between State-local responsibility and individual needs. The recent arrival in a State may differ in no measure in his need or as a general public problem from a person who has lived in the State all his life. Under existing law the Federal Government stands equally ready to share in the costs of providing public assistance to each.

A condition upon approval of Federal participation in [aid to dependent children] has limited to 1 year the residence requirements which may be imposed. In the case of [aid to] the aged and the blind, [a longer period of residence may be required].¹⁵ Obviously, exclusions on the basis of residence

¹⁵ The Social Security Act forbids approval of any State plan for old-age assistance or aid to the blind which imposes as a condition of eligibility "any residence requirement which excludes any resident of the State who has resided therein 5 years during the 9 years immediately preceding * * * application * * * and has resided therein continuously for 1 year immediately preceding the application." (Title I, sec. 2 (b) (2) and title X, sec. 1002 (b) (1)).

would be greatly reduced if the maximum permissible residence requirements were made 1 year for these groups. Such a change would doubtless lessen the problem, but it would still leave the issue unsettled.

From the viewpoint of Federal participation in public assistance it is difficult to justify deprivation of aid of an American citizen solely on the grounds of his residence. The vast majority of administrators and students of public assistance believe that residence requirements are inappropriate, cruel, administratively cumbersome and expensive, and socially unjustifiable.¹⁶

Residence requirements necessitate considerable unproductive administrative effort. Proofs are often difficult to obtain, especially if the applicant has lived in various communities. Delays in providing assistance are embarrassing, particularly where the delay is long because of difficulties of obtaining proof to satisfy complicated interpretations of the meaning of residence. Moreover, the question still remains as to what the community is to do about needy individuals found ineligible because of residence requirements.

For those who fear that a State with fairly high payments may be flooded with needy cases from areas where payments are very low, the proposed variable Federal grants [see Varying Federal Participation to State Ability, page 42 of this digest] might considerably change the viewpoints, since such grants would minimize wide differences in assistance payments.

The problem of nonresidence

Munitions and equipment for war have been manufactured not only in centers of peacetime industry but also in newly built centers in various parts of the country. The Bureau of the Census has estimated ¹⁷ that 7,800,000 people were living, in March 1945, in a different State from that in which they lived in December 1941. They represent about 6 percent of the Nation's population. The complex process of reconversion will require further shifts of population.

Suggested solutions of the problem of residence

There appear to be three principal approaches to the solution of the problem of residence requirements in public assistance.

Uniform laws regarding residence.—One approach might be the establishment of a uniform 1-year residence requirement for all States, with eligibility retained in one State until gained in another. This provision would not eliminate extensive investigation of each applicant's residence, including extensive interstate correspondence to determine receipt of relief or to prove residence established in another State.

¹⁶ For recommendations of several groups see pp. 357 to 359 of *Issues in Social Security*. Further details on the effect of residence requirements are presented on pp. 306 to 308.

¹⁷ Civilian Migration in the United States, December 1941 to March 1945 (U. S. Bureau of the Census, Population—Special Reports, series P-S No. 5, September 1945).

Federal care for nonresidents.—A second approach—assumption by the Federal Government of the entire cost of assistance to nonresidents—retains residence requirements but only for fiscal reasons. Questions would arise as to whether the recipients for whom the Federal Government was wholly responsible would be cared for under State or Federal standards. Experience in administering the Federal transient program under the Federal Emergency Relief Administration has shown the difficulty of classifying people on the basis of residence. States might be inclined to classify as many applicants as possible as nonresidents and so shift the entire burden of their support to the Federal Government. Far from lessening investigations of residence, [this proposal] might actually increase this activity.

P. 310

Abolishing residence requirements.—The only approach which would remove all the existing difficulties inherent in the residence requirements—investigations, delays in payment, etc.—would be to require that the State plan contain no residence requirement. Abolishing residence requirements does not mean, of course, that assistance will be paid to persons who live in one State but apply for assistance in a neighboring State. It does mean, however, that persons living in a State or finding themselves stranded in a State without other means of support would not be denied aid.

P. 310

Such an approach differs from the other approaches in degree, but not in major effects on taxpayers. Under either of the first two approaches individuals are assured public assistance for the period necessary to qualify them for assistance under the laws of a State. Thus, after the first year, the burden of assisting new residents would be the same under any of the foregoing.

REDEFINITION OF ECONOMIC REASONS FOR ELIGIBILITY

P. 311

The expansion of Federal participation in assistance to the groups discussed above would provide for reasonably adequate aid under present concepts of need. Certain [suggestions put forward from time to time] propose altering the basic concept of need, either by exempting certain income and resources or by providing a fixed grant irrespective of need.

The Social Security Act, as currently interpreted, requires consideration of all income and resources of the applicant, or recipient, except those that are inconsequential. This provision is based on the thesis that equal need shall be met by equal aid.

During the war a special provision was made for allowing exemption of earnings from agriculture under certain conditions for old-age-assistance recipients. The justification for this exemption was that it would encourage such persons to work on farms where there was emergency need for labor.

The result of a fixed exemption would be to break down the relation of assistance to need.

If exemptions [of, for example, \$20 to \$25 per person per month were authorized] a person requiring \$40 per month to meet his need could have a monthly total of \$60 or \$65 if he were fortunate enough to have earnings equivalent to the exemption. An individual with need for \$20 and income of \$20 would still be eligible to receive \$20 in assistance.

[Exemptions of specified resources or income, in determining need for public assistance] would naturally increase the number of persons eligible for assistance by a considerable, unpredictable, amount. It would also increase considerably the amount of assistance to the present group of eligibles. The net effect would be a very marked increase in public expenditures in favor of groups whose need is least.

P. 312

"Pensions"

Flat grants to old-age assistance or aid to the blind recipients without means tests, or with test to the extent only that means can be determined through income-tax reports [have been proposed in various quarters].

P. 317

Such proposals do not properly fall under the classification of "assistance," since the primary principle of assistance is to meet need according to the extent that it is present to insure adequate living for each individual, but not to put a premium on age and disability. There are arguments undoubtedly which could be advanced both for and against such "pensions," but they do not properly belong in a discussion of "assistance."

C. VARIABLE GRANTS

To the extent that low levels of assistance are caused by limited ability of the State to make payments, no significant increase in payments is likely in the absence of Federal action. [Similarly, to the extent that low payments are caused by the inability of localities in some States to pay a share of assistance costs, payments cannot be materially increased without equalization of funds within the State.]

P. 285

VARIABLE GRANTS TO STATES

The present basis of Federal participation does not recognize differences in the ability of States to finance public assistance, nor does it recognize differences growing out of greater incidence of poverty in the low-income States.¹⁸

P. 285

Comparative fiscal ability among States

Ability of a State to make assistance payments is dependent upon its resources. A State's income is largely determined by its tax receipts. However, tax receipts vary with the effort which a State makes to tax itself. Since the ability of a State to collect taxes depends in large part upon the income of its citizens, the total of individual incomes in the State is a more certain indication of ability than the taxes collected.

P. 286

¹⁸ Although this was written before the 1946 amendments came into effect, it is still true.

Per capita income.—From 1929 to 1944 there have been great shifts in the general level of income payments, but the ranking of individual States within the range of per capita income payments has remained rather constant. Wide differences between States with high and low per capita income appear in every year.¹⁹ P. 286

Except in the war years, per capita income in the State with the highest per capita income has generally been at least five times as great as in the State with the lowest. Even in 1944, when the lowest State per capita income was \$528, the highest State per capita income was \$1,519, or nearly three times as much.

[In 1946 when the national average per capita income was approximately \$1,200 there were 4 States (California, District of Columbia, Nevada, and New York) in which the average exceeded the national average by at least 25 percent and 10 States²⁰ in which the average fell below the national average by the same margin. In relative terms the lowest State per capita income—that in Mississippi—was only about a third of the New York average and less than a third of that in Nevada.]

Relation between per capita income and assistance payments.—The size of [assistance grants in the various States reflects] differences in the fiscal ability of the States. Only 1 of the 18 States above average in per capita income [based on 1941–43 average] made an average monthly [old-age assistance] payment [in December 1944] greatly below the national average, while 9 were appreciably above that average. On the other hand, of the 31 States with incomes below the national average, only 6 had an average old-age assistance payment which was among the 10 lowest in the country, and only 1, New Mexico, exceeded the national average. These 10 States have 18 percent of the population of the United States yet in 1944 they received only 10 percent of all Federal funds granted for public assistance under the Social Security Act.²¹ P. 288

While State and local tax effort, whether for operating expenditures or public assistance, does not show a close State-by-State correlation with State per capita income, there is a clear tendency for the below average per capita income States to make greater, not less, effort. Even if all States were to make the same effort, however, the results would vary widely in terms of per capita amounts.²² P. 288

Incidence of poverty

Past experience indicates that the low-income States not only have relatively smaller resources but also must provide for a relatively larger number of needy persons. Recipient loads for aid to dependent children and old-age assistance P. 290

¹⁹ Pertinent State data are presented on pp. 347 to 348 of Issues in Social Security.

²⁰ Alabama, Arkansas, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, and Tennessee.

²¹ For further details see pages 286 to 288 of Issues in Social Security. The relationship between per capita income and old-age assistance payments in the various States is shown diagrammatically on p. 287 of the Report.

²² For further details see pp. 288 to 293 of Issues in Social Security.

show that the poorer States have a relatively greater number of needy persons and, as a rule, appear willing to recognize such need. Only 5 of the 18 States with above average per capita income [in June 1945] had old-age assistance recipient loads above average, while 9 of the 31 States with below average per capita income had old-age assistance loads below average. A similar situation exists in aid to dependent children.

[The relationship between recipient rates for aid to dependent children and old-age assistance, on the one hand, and per capita income payments, on the other, is shown graphically for the various States on page 293 of the report. Further details are presented on pages 290 to 292.]

[The proportion of aged persons receiving old-age assistance (in June 1945) ranged from 517 per 1,000 in Oklahoma to 51 per 1,000 in the District of Columbia. The proportion of children under 18 receiving aid to dependent children ranged from 47 per 1,000 in Oklahoma to 7 per 1,000 in New Jersey. In aid to the blind, the rates ranged from 54 per 100 estimated blind population in Maine²³ to 5 per 100 in Connecticut. Recipient rates for the special assistance programs in the various States in June 1945 and June 1947 are presented in table 3, page 47 of this digest.]

[In June 1947 (as may be noted in table 3, page 47 of this digest) the incidence of old-age assistance and aid to dependent children in the States having the highest rates were about 11 times those in States having the lowest rates.]

Reasons for variation.—Numerous circumstances account for the sharp State variations in the proportions of the particular population groups concerned receiving aid. States, of course, differ in the incidence of poverty. States differ not only in the extent of need, but also in the standards which they apply in determining need. Differences in State eligibility conditions also influence the number of recipients in relation to population. Citizenship is a condition of eligibility in some States but not in others.

In aid to dependent children, the definition of "incapacity" of a parent varies from State to State as does also the definition of a "continued absence from home."

In States which are highly industrialized, relatively more people are receiving retirement or survivors' benefits than in States with large numbers of agricultural workers who are not covered by the insurance program.

Varying Federal participation to State ability

The above evidence appears to indicate that although low per capita income States tend to exert comparatively great financial effort, needy persons in those States receive comparatively less assistance from both Federal and State sources than persons in States with high per capita income. The difference can be reduced by providing the low per

P. 328

P. 332

P. 290
to 292

²³ The rate in Pennsylvania was 85 per 100 estimated blind population but the Pennsylvania plan has not been approved by the Federal Government and therefore does not receive Federal funds for this program.

capita income State with a greater proportion of its total assistance expenditure from Federal funds.

Proposed equalization plan.—Several methods have been suggested by which Federal participation may be varied according to State financial ability. The method most frequently suggested for assistance programs provides for varying Federal participation from 50 to 75 percent of the total State assistance expenditure. The basis suggested for this variation is State per capita income, which is a quotient of income payments (which represents financial ability of the State) and population (which, roughly, represents differences in total assistance needs). According to this method, States with per capita income below the national average would receive "special aid" through raising Federal participation [to] 50 percent [plus] half the percent by which the State's per capita income falls below national average per capita income.

Under this method the 18 States with above average per capita income would receive \$1 for each dollar expended from State-local funds. The 31 States with below average per capita income would receive from \$1.08 to \$3 for each dollar expended from State-local funds. If Federal participation were not limited to 75 percent, one State, according to 1941-43 per capita income, would by formula receive 78 percent Federal participation. In times of depression the relative range of per capita income among States is greater, and more States by formula, if not limited to 75 percent, would receive greater proportionate Federal participation.

P. 292

While under the logic of this method States with above average per capita income should perhaps receive Federal matching proportionately below 50 percent, such action might tend to discourage program development in those States, with no advantage to the below average per capita income States.

P. 292

*Estimates of its cost to Federal Government.*²⁴—For the United States as a whole, the low estimate [of this equalization plan] for the four programs totals \$518,000,000 per year from Federal funds—an increase of \$132,000,000 or 34 percent over 1943-44; the high estimate is \$669,000,000, which is higher than Federal expenditures in 1943-44 by \$284,000,000 or 74 percent. About one-fourth of the increase in Federal funds would result from removing Federal matching maximums and the remaining 75 percent would be divided almost equally between special Federal aid to low-income States and Federal grants to States for general assistance. In relation to [1943-44] expenditures, the low-income States would benefit more from the changes than the high-income States.

P. 319
to 320

²⁴ The basis on which these estimates were made and the anticipated effects of the equalization plan upon recipient rates and upon average payments are discussed in detail on pp. 318-324 and 350-351 of *Issues in Social Security*.

EQUITABLE DISTRIBUTION OF FUNDS WITHIN STATES

Increase in Federal grants to States will not result in equitable treatment of needy individuals unless satisfactory methods are worked out for apportioning Federal and State funds among subdivisions within States. Whether or not a needy person receives aid often depends on whether he lives in one county or a few miles away in another. This problem is particularly acute in the States that now require localities to share in financing one or more of the special types of public assistance. In these States, localities usually receive Federal and State funds only as they are able to raise local funds to be matched. P. 292

County differences in assistance payments

Differences among localities in assistance payments are like those among States. More prosperous areas have large tax resources and proportionally fewer people to assist. Usually they make higher payments than are made in poor areas, where relatively more people are in need.

County fiscal burdens

Most local governments must rely on the property tax as their major source of revenue. Communities with low property values, therefore, have great difficulty in carrying their share of an adequate—or even an inadequate—assistance program. Fiscal ability tends to be low where need is great, and the poorer localities often bear a disproportionately large financial burden in paying their required share of assistance.

If public assistance is to be adequate in the poorer localities without a further drain on their overtaxed resources, some way must be devised to equalize the fiscal burden among counties. In financing education, the principle of granting more State aid to poorer localities is well established.

D. MISCELLANEOUS PROVISIONS

LIMITATION OF LIENS

The Social Security Act does not require States to take liens on applicants' or recipients' property or to make recovery for assistance paid to recipients; in fact, the act tends to reduce the incentive for such practices because it provides that if a State makes recoveries the Federal Government shall receive a pro rata share. P. 313

Approximately one-third of the States impose some type of lien provision or other device for securing the State's interest in a recipient's property for recovery of assistance paid to him. In some States a lien is imposed on all property of an applicant, both real and personal. In other States, liens are imposed on real property alone, or on personal property alone, sometimes on that part which is in excess of a specified amount. The effect of these practices is to condition or restrict the recipient in the use of his resources.

Consideration might be given, therefore, to a requirement that States' authority to take liens or to impose other controls be limited to real property and personal property other than cash and that it be limited to securing the agency's interest in that property for recovery, so as not to interfere with the recipient's use of that property. Moreover, the provisions in many State laws permitting States to enforce their claims only after the death of the recipient and surviving spouse or other dependent might well be made applicable for all States retaining recovery provisions. P. 314

FEDERAL PARTICIPATION IN BURIAL PAYMENTS

P. 316

The Social Security Act does not provide for Federal matching in respect to payments of burial expense for deceased old-age assistance recipients. One old-age assistance recipient in 14 dies each year. If relatives or friends are unable to pay for the expenses of burial, this cost is borne variously by State or local units. If Federal matching were provided for the expenses of burial it would be expedient to establish matching on a payment-to-vendor basis.

FEDERAL PARTICIPATION IN COST OF ADMINISTRATION OF OLD-AGE ASSISTANCE

[Included in the report was the recommendation (supported by a considerable body of statistical data) that the then prevailing legal provisions governing Federal participation in costs of administering old-age assistance be modified. The 1946 amendments, enacted after the report was issued, changed the provision for Federal participation in the cost of administering old-age assistance to a 50-50 basis, as in the other special assistance programs.]

If special Federal aid is made available to low income States, matching of administrative expense for [all programs] should be on the same basis. P. 316

TABLE 1.—*Recipients of public assistance, by program, 1936-47*¹

Year and month	Special assistance in States with approved plans				General assistance (cases)
	Old-age assistance (individuals)	Aid to dependent children		Aid to the blind (individuals)	
		Families	Children		
January:					
1936 ²	431,000	123,000	305,000	37,300	2,219,000
1937.....	1,148,000	118,000	300,000	29,400	1,662,000
1938.....	1,602,000	218,000	541,000	33,600	1,893,000
1939.....	1,790,000	274,000	670,000	43,400	1,772,000
1940.....	1,924,000	312,000	754,000	46,100	1,674,000
1941.....	2,078,000	364,000	883,000	49,100	1,257,000
1942.....	2,243,000	393,000	948,000	53,100	836,000
1943.....	2,217,000	338,000	823,000	54,500	446,000
1944.....	2,137,000	270,000	672,000	57,500	289,000
1945.....	2,059,148	254,622	641,892	56,241	259,000
1946.....	2,059,344	279,829	716,574	55,805	276,000
1947:					
January.....	2,212,945	354,342	905,785	60,186	336,000
February.....	2,227,868	363,603	929,601	60,451	344,000
March.....	2,243,392	374,339	957,026	60,863	344,000
April.....	2,255,525	384,004	979,516	61,210	339,000
May.....	2,259,677	391,261	996,843	61,658	338,000
June.....	2,271,007	396,098	1,009,360	62,085	335,000
Percentage change: January 1936 to January 1947.....	+413	+188	+197	+61	-84.9

¹ Source of data: Social Security Bulletin, various issues. Special assistance data through 1944 taken from Issues in Social Security, p. 338.

² Month prior to operations under the Social Security Act.

TABLE 2.—*Average public-assistance payments, by program, 1936-47*¹

Year and month	Special assistance in States with approved plans				General assistance, per case
	Old-age assistance, per recipient	Aid to dependent children		Aid to the blind, per recipient	
		Per family	Per child		
January:					
1936 ²	\$16.34	\$28.63	\$11.58	\$23.70	\$21.70
1937.....	18.81	28.30	11.12	25.51	23.08
1938.....	19.49	32.18	12.96	24.06	22.56
1939.....	19.59	32.52	13.28	23.30	26.22
1940.....	19.87	32.31	13.37	23.44	25.78
1941.....	20.49	33.00	13.62	23.46	25.20
1942.....	21.40	33.78	13.99	24.08	24.13
1943.....	23.53	36.61	15.05	25.10	24.47
1944.....	26.82	41.75	16.76	27.69	27.30
1945.....	28.52	45.68	18.12	29.53	28.80
1946.....	31.06	52.63	20.55	32.32	33.72
1947:					
January.....	35.39	62.32	24.38	36.40	40.10
February.....	35.44	62.67	24.51	36.61	39.56
March.....	35.98	63.29	24.76	37.43	39.65
April.....	35.99	62.80	24.62	37.67	40.29
May.....	35.92	62.09	24.37	37.71	40.27
June.....	36.04	61.68	24.20	37.87	39.18
Percentage change: January 1936 to January 1947.....	+117	+118	+111	+53.6	+84.8

¹ Source of data: Social Security Bulletins, various issues and unpublished memorandum from Federal Security Agency, October 29, 1947. Special assistance data through 1944 taken from Issues in Social Security, p. 339.

² Month prior to operations under the Social Security Act.

TABLE 3.—*Recipient rates for public assistance in June 1945 and 1947, by program and by State (Alaska and Hawaii not included)*

State	June 1945 ¹				June 1947 ²			
	Old-age assist- ance ³	Aid to the blind ⁴	Aid to depend- ent chil- dren ⁵	General assist- ance ⁶	Old-age assist- ance ³	Aid to the blind ⁴	Aid to depend- ent chil- dren ⁵	General assist- ance ⁶
United States average.....	207	31	16	-----	214	33	23	547
Alabama.....	209	10	13	-----	325	13	19	206
Arizona.....	349	45	18	-----	361	59	28	779
Arkansas.....	287	29	18	-----	316	31	25	195
California.....	243	51	8	-----	245	58	12	545
Colorado.....	405	27	25	-----	469	24	30	646
Connecticut.....	94	5	10	-----	99	6	14	N. A.
Delaware.....	57	⁷ N. A.	10	-----	52	17	8	N. A.
District of Columbia.....	51	12	10	-----	47	12	20	192
Florida.....	280	47	21	-----	325	52	39	N. A.
Georgia.....	380	25	8	-----	415	26	14	173
Idaho.....	268	34	18	-----	277	34	25	153
Illinois.....	190	43	22	-----	187	41	25	581
Indiana.....	181	35	13	-----	159	33	17	598
Iowa.....	205	31	11	-----	188	30	15	443
Kansas.....	198	34	14	-----	190	36	22	488
Kentucky.....	237	34	13	-----	224	34	23	N. A.
Louisiana.....	303	21	27	-----	352	22	33	440
Maine.....	182	54	14	-----	183	51	19	686
Maryland.....	84	12	13	-----	83	13	21	923
Massachusetts.....	185	14	15	-----	203	17	18	653
Michigan.....	228	17	17	-----	238	19	26	836
Minnesota.....	233	24	15	-----	219	24	18	534
Mississippi.....	260	20	9	-----	300	26	17	35
Missouri.....	293	⁷ 41	26	-----	314	⁷ 41	47	701
Montana.....	262	40	21	-----	237	45	28	373
Nebraska.....	210	23	13	-----	207	23	19	258
Nevada.....	226	⁷ 17	⁷ N. A.	-----	219	⁷ 16	⁷ 3	454
New Hampshire.....	134	31	13	-----	130	34	19	525
New Jersey.....	71	9	7	-----	67	9	9	296
New Mexico.....	253	28	32	-----	290	31	42	520
New York.....	98	15	13	-----	97	17	26	921
North Carolina.....	212	29	11	-----	206	34	15	165
North Dakota.....	203	14	20	-----	192	15	20	227
Ohio.....	199	26	10	-----	195	28	12	615
Oklahoma.....	517	47	47	-----	574	56	86	N. A.
Oregon.....	187	22	9	-----	200	23	17	531
Pennsylvania.....	108	⁷ 85	20	-----	113	⁷ 93	32	566
Rhode Island.....	116	10	15	-----	131	12	28	839
South Carolina.....	256	17	14	-----	305	20	19	309
South Dakota.....	270	23	17	-----	243	22	23	348
Tennessee.....	239	27	27	-----	239	29	32	N. A.
Texas.....	440	40	11	-----	474	44	15	N. A.
Utah.....	379	21	21	-----	341	23	26	432
Vermont.....	143	23	14	-----	151	28	17	456
Virginia.....	97	15	10	-----	88	17	12	252
Washington.....	354	22	17	-----	373	24	31	508
West Virginia.....	196	32	28	-----	174	33	36	475
Wisconsin.....	171	31	14	-----	170	29	18	349
Wyoming.....	227	41	10	-----	232	42	12	295
Range:	(Okla- homa)	(Penn- sylvania)	(Okla- homa)	-----	(Okla- homa)	(Penn- sylvania)	(Okla- homa)	(Mary- land)
Highest.....	517 (Delaware)	⁷ 85 (Connecticut)	47 (New Jersey)	-----	574 (Delaware)	⁷ 93 (Connecticut)	86 (Delaware)	923 (Mississippi)
Lowest.....	⁸ 57	5	7	-----	⁸ 52	6	⁸ 8	35
Lowest as per- centage of highest.....	11.0	5.9	14.9	-----	9.1	6.5	9.3	3.8

¹ Source of data: For old-age assistance and aid to dependent children, Issues in Social Security, table 15, p. 348; for aid to the blind, Social Security Bulletin, September 1945, p. 19, amended to include rates for programs not approved under the Social Security Act.

² Source of data: For old-age assistance, aid to dependent children, and general assistance, Social Security Bulletin, August 1947, table 7, p. 36; data for the blind apply not to June 1947, but to December 1946—Source: Social Security Bulletin, March 1947, table 6, p. 32, amended to include rates for programs not approved under the Social Security Act.

³ Number of recipients per 1,000 population aged 65 and over.

⁴ Number of recipients per 100 estimated blind population.

⁵ Children receiving aid to dependent children per 1,000 population under 18 years.

⁶ Recipients of general assistance per 100,000 estimated civilian population. Count of persons receiving general assistance for June 1945, not available.

⁷ Program not approved under Social Security Act.

⁸ Lowest exclusive of District of Columbia.

⁹ Lowest exclusive of Nevada which has no plan approved under the Social Security Act.

N. A.—Not computed. Population data or recipient data not available or incomplete.

TABLE 4.—Average monthly public assistance payments in June 1945 and 1947, by program and by State¹

States	June 1945				June 1947			
	Old-age assistance per recipient	Aid to the blind per recipient	Aid to dependent children per family	General assistance per case	Old-age assistance per recipient	Aid to the blind per recipient	Aid to dependent children per family	General assistance per case
United States average.....	\$29.46	\$29.97	\$47.46	\$29.06	\$36.04	\$37.91	\$61.68	\$39.18
Alabama.....	15.51	15.93	25.04	13.92	17.54	20.00	31.48	15.87
Alaska.....	34.49	(²)	^{3 4} 53.71	27.13	39.79	(²)	31.31	29.62
Arizona.....	38.55	46.01	39.52	22.08	47.58	57.29	46.76	31.30
Arkansas.....	17.99	19.87	28.69	11.86	18.25	21.27	36.12	12.21
California.....	47.32	47.77	81.20	37.42	52.61	62.84	101.47	48.15
Colorado.....	41.35	36.67	53.22	31.00	65.11	45.48	68.59	38.30
Connecticut.....	36.73	35.72	77.39	32.34	43.87	40.34	93.06	39.66
Delaware.....	15.84	(²)	67.88	24.53	22.66	28.48	⁴ 67.74	35.90
District of Columbia.....	31.89	35.30	59.95	36.49	40.07	42.21	74.26	48.04
Florida.....	28.58	29.95	33.50	N. A.	36.59	38.01	35.31	N. A.
Georgia.....	11.42	14.15	24.96	12.07	17.04	20.42	35.30	14.55
Hawaii.....	22.59	25.09	59.34	31.58	35.38	40.66	93.06	47.70
Idaho.....	30.22	31.44	36.44	20.95	41.71	46.68	78.45	28.91
Illinois.....	31.93	33.73	49.87	31.42	39.57	41.20	78.63	43.32
Indiana.....	25.61	29.66	36.47	21.79	30.33	32.31	42.49	22.96
Iowa.....	31.72	33.11	27.21	18.37	39.72	46.74	34.67	25.31
Kansas.....	28.82	31.20	49.13	28.98	34.74	39.91	70.70	42.37
Kentucky.....	11.46	12.96	21.72	N. A.	17.38	18.40	35.06	N. A.
Louisiana.....	23.65	27.25	44.71	17.93	24.28	29.84	45.58	21.16
Maine.....	29.59	30.62	63.71	30.85	34.21	34.31	89.87	38.32
Maryland.....	27.77	31.22	37.53	32.35	30.88	34.05	48.28	34.35
Massachusetts.....	42.76	44.39	80.32	32.10	50.60	51.46	95.58	38.49
Michigan.....	30.65	34.46	60.25	32.00	35.94	40.36	77.83	38.94
Minnesota.....	30.12	37.68	41.91	26.40	37.07	44.52	55.84	36.32
Mississippi.....	15.42	22.18	25.91	8.50	17.32	23.87	26.43	10.12
Missouri.....	^{3 4} 25.00	33.72	19.83	35.05	³ 30.00	33.46	24.62	24.62
Montana.....	31.10	34.44	45.13	24.45	37.80	40.25	67.22	27.25
Nebraska.....	28.74	29.34	32.79	21.10	40.27	40.51	81.23	26.03
Nevada.....	38.42	^{3 4} 40.79	³ 28.71	20.62	47.47	^{3 4} 44.15	³ 31.60	21.51
New Hampshire.....	30.03	30.73	68.37	26.96	36.70	39.70	78.45	31.03
New Jersey.....	31.74	33.46	58.52	34.66	40.76	42.60	78.49	47.44
New Mexico.....	31.81	29.00	38.56	22.69	35.85	39.14	48.54	20.94
New York.....	34.79	39.13	74.58	45.16	46.99	52.28	98.02	65.55
North Carolina.....	12.50	18.63	24.79	10.69	18.05	25.95	35.44	13.50
North Dakota.....	33.32	32.33	54.96	23.34	39.45	37.72	74.90	31.28
Ohio.....	29.85	27.00	54.27	27.94	39.56	36.02	66.05	39.81
Oklahoma.....	29.27	34.37	34.16	N. A.	42.33	42.91	44.98	N. A.
Oregon.....	35.37	46.25	79.46	39.79	41.87	49.61	89.74	46.90
Pennsylvania.....	30.00	³ 29.79	63.71	26.29	33.96	³ 39.76	72.12	33.56
Rhode Island.....	33.67	31.39	67.85	31.44	39.66	41.25	77.47	43.60
South Carolina.....	14.14	20.24	24.18	11.34	20.23	23.98	27.60	12.57
South Dakota.....	24.53	22.15	40.41	21.15	32.42	30.04	46.03	24.68
Tennessee.....	16.08	19.99	30.23	N. A.	18.38	22.93	35.09	N. A.
Texas.....	23.90	24.36	20.80	N. A.	28.92	31.52	41.73	N. A.
Utah.....	38.73	38.90	73.24	40.17	42.22	48.17	92.03	48.59
Vermont.....	22.30	28.49	34.51	23.40	30.81	36.88	46.34	26.05
Virginia.....	13.70	18.14	29.56	16.68	17.63	22.72	39.46	19.98
Washington.....	48.29	54.12	90.20	48.49	53.02	61.00	104.63	49.32
West Virginia.....	17.98	20.98	32.67	13.98	15.08	18.06	28.90	14.66
Wisconsin.....	29.14	29.36	54.92	23.59	36.00	36.55	79.83	37.00
Wyoming.....	36.30	38.89	59.47	31.40	48.72	52.28	86.37	44.13
Range:	(Washington)	(Washington)	(Washington)	(Washington)	(Colorado)	(California)	(Washington)	(New York)
Highest.....	48.29	54.12	90.20	48.49	65.11	62.84	104.63	65.55
Lowest.....	(Georgia)	(Kentucky)	(Texas)	(Mississippi)	(West Virginia)	(West Virginia)	(Mississippi)	(Mississippi)
Lowest as percentage of highest.....	11.42	12.96	20.80	8.50	15.08	18.06	26.43	10.12
	23.6	23.9	23.1	17.5	23.2	28.7	25.3	15.4

¹ Source of data: Social Security Bulletin, August 1945, tables 2, 4, 5, pp. 42, 43, 44; August 1947, tables 2, 4, 5, 6, pp. 33, 35, 36.

² No program.

³ Program not approved under Social Security Act.

⁴ Partially estimated.

NOTE.—N. A. Not computed. Population data or recipient data not available or incomplete.

PART III. UNEMPLOYMENT COMPENSATION

PREPARED BY

WILLIAM R. CURTIS

Chief, Administrative Standards Division,
Bureau of Employment Security,
Social Security Administration

NOTE.—In some cases the text presented in this part is the exact language used in Issues in Social Security. In other cases the language is new. Factual information has been brought up to date. Issues that have arisen and proposals for change that have been made since Issues in Social Security was published are included and the paragraphs which discuss them are indicated in brackets as follows: [].

PART III—UNEMPLOYMENT COMPENSATION

CHAPTER I. THE FEDERAL-STATE SYSTEM OF UNEMPLOYMENT COMPENSATION IN THE UNITED STATES

INTRODUCTION

Although unemployment compensation had been the subject of discussion in this country for many years prior to congressional consideration of the Social Security Act, the only tangible result was the passage by Wisconsin of an unemployment-compensation law in January 1932. The Social Security Act was passed by the Congress on August 9, 1935, and was approved by the President on August 14. Within less than 2 years after the approval of the Social Security Act, all States had passed unemployment-compensation laws. The unemployment-compensation provisions of the Social Security Act and the State laws were held constitutional by the Supreme Court of the United States in May 1937.

P. 363
to 364

The Social Security Act did not establish an unemployment-compensation system; it contained provisions which encouraged States to do so. The act imposed a uniform national tax of 3.0 percent on the pay rolls of specified employers, with the provision that employers who paid a tax to a State with an approved law could offset the State tax against the national tax up to 90 percent of the Federal levy.¹ This offset device, of course, resulted in the passage of State laws. If the States had not acted, the proceeds of the pay-roll tax would have gone into the general fund of the United States Treasury. Because of the Federal provisions, the States generally have established their standard rate as 90 percent of the Federal tax, or 2.7 percent. As will be pointed out later, however, the Federal act also provided for additional credits against the Federal tax, which eventually nullified the uniform national levy.

P. 364
to 365

In order to remove all possible obstacles to State action, the Social Security Act provided that the cost of administering the unemployment compensation functions established by State law should be financed completely by Federal funds. The Congress appropriates funds to the Social Security Administration (formerly the Social Security Board)² out of which it makes grants to States for the administration of their laws. The States thus bear directly no part of the cost

¹ In 1939 the unemployment-compensation pay-roll-tax provisions were transferred to subchapter C of the Internal Revenue Code and are now known as the Federal Unemployment Tax Act.

² Reorganization Plan No. 2 of 1946, effective July 16, 1946, abolished the Social Security Board. Its functions were largely taken over by the Social Security Administration, established by the Federal Security Administrator.

of administering unemployment compensation functions. The source of funds for congressional appropriations for grants to States, although not earmarked for this purpose, is generally considered to be the Federal unemployment tax collected by the Federal Government, which amounts generally to 0.3 percent of the taxable wages paid by employers subject to it.

Under the Social Security Act, the States have wide latitude as to the provisions of their unemployment compensation laws. The States determine the coverage and the benefits they will pay. They largely determine the conditions under which they will pay benefits, and the kind of administrative machinery they use.

Although the States have comparative freedom in establishing their unemployment compensation systems, the Social Security Act places certain responsibilities on the Federal Government. The Federal responsibilities, except for tax collections and trust-fund functions, are administered by the Social Security Administration. The Administration must review State laws with respect to conformity with certain specified provisions in the Federal act before they can be approved for the normal tax offset and for certification for administrative grants. The act also requires that State administration performance meet certain standards in order to be certified for administrative grants. In general, the requirements a State law must meet are intended to safeguard the solvency of its funds, prevent the depression of labor standards, and insure reasonably efficient administration.

P. 365
to 368

THE PURPOSE OF UNEMPLOYMENT COMPENSATION

In spite of the fact that unemployment compensation had been the subject of discussion in this country for almost a generation and that laws have been in existence in all States for at least 11 years, there is still some disagreement as to its primary purpose and its basic principles. It is generally conceived of as a multiple-purpose program, although different groups emphasize different aspects of it.

Perhaps the most generally accepted view is that unemployment compensation is justified primarily as a method of providing income needed to maintain unemployed workers and their families. Instead of emphasizing benefits as a primary objective, however, some regard the program essentially as a device for stabilizing employment. This concept is manifested primarily in experience rating provisions in State laws, which give employers with relatively stable employment reduced tax rates.

Still others justify unemployment compensation, at least in part, as a device for maintaining consumer purchasing power. This justification emphasizes the effect of benefit payments on business in general, instead of on the individual benefit recipient. It is also conceived of by some as an appropriate device to provide for the best utilization of the

P. 368
to 371

labor force. In any case, it is generally agreed that the program should contain safeguards to prevent its being used to depress labor standards or to limit the mobility of labor.

Even though unemployment compensation generally is viewed as primarily a method of providing benefits to unemployed workers, there are differences of opinion as to the extent of protection that the program can properly provide. To some it is thought of as a program that should be limited in scope, paying relatively small benefits for relatively short periods. Others hold a much broader view of the protection that it can appropriately provide. They would make the program a major device for meeting the risks of unemployment. It would extend, in principle at least, to all those who work for wages; it would pay relatively high benefits; and it would pay them for relatively long periods of time.

SUMMARY OF OPERATIONS UNDER THE FEDERAL-STATE SYSTEM

In 1946, the most recent year for which figures are available, the total number of different workers who worked in employment covered by State laws was about 45,800,000. Of those, 37,000,000 worked sufficiently long to qualify for benefits should they become unemployed. About four and a half million workers drew some benefits during the year, at an average weekly rate of \$18.50. The average weekly payment has since declined to \$17.68 in the quarter ending June 30, 1947. From the beginning of the program through June 30, 1947, the State agencies collected about \$11,000,000,000 in contributions and in interest, and paid out some \$4,000,000,000 in benefits, leaving an approximate balance of about \$7,000,000,000 in reserves, the highest in history. During the period from January 1936 through June 1947, Federal unemployment tax collections amounted to \$1,421,000,000, while grants to States for administration approximated \$548,000,000 and expenditures by Federal agencies for the same purpose approximated \$35,000,000, leaving an approximate balance of Federal unemployment tax collections of \$838,000,000. This balance goes into a special fund for use, until December 31, 1949, in making advances to States whose funds become low.

P. 371

UNEMPLOYMENT COMPENSATION DURING THE RECONVERSION

[While unemployment compensation has never operated through a serious depression, it has functioned during the reconversion period, which involved mass displacements of millions of people. It may be worth while to look briefly at experience during the period from August 1945, through December 1946.

[Millions of workers who were laid off after the end of the war had acquired rights to higher benefits than ever before because of high wartime wages. With the high level of employment prevailing at this time, however, many of the

workers who lost their wartime jobs found other jobs without filing claims. Their rights to substantial benefits did not prevent them from taking suitable employment where available. Even among the 11,000,000 workers who filed claims for benefits during the period, more than one-third were re-employed during the waiting period, and drew no benefits. During these 17 months, when millions of war jobs were terminated and when millions of servicemen were being integrated into civilian life, the number of beneficiaries in any week did not exceed 3 percent of the number of workers with rights to benefits, while the total number of beneficiaries was less than a fifth of the insured covered workers.

[While economic conditions were on the whole very good, the postwar period was marked by lay-offs due to retooling, material shortages, price uncertainties and labor disputes. Nearly 7,000,000 workers drew benefits at some time during this period. On the average, benefits were drawn for about 12 weeks and about 40 percent of the beneficiaries were still unemployed when they drew their last check. The average weekly benefit paid for total unemployment was \$18.63, and a total of 1.5 billion dollars was paid out in benefits during the 17-month period.]

[Because of this large outlay, and because the average rate of employer contributions declined to a new low of 1.4 percent, funds available for benefit payments failed to rise during 1946 for the first time in the program's history. Still, the nearly \$7,000,000,000 of available reserves at the end of 1946 were approximately the same as they had been at the end of the war. Thus, unemployment compensation functioned through the reconversion practically without dipping into accumulated reserves.]

CHAPTER II. THE BENEFIT STRUCTURE IN UNEMPLOYMENT COMPENSATION

State laws specify the conditions under which workers may receive benefits, and the amounts they may receive. The amounts depend upon each worker's record of employment and wages during a past period, ordinarily of four consecutive calendar quarters, called a base period. The benefit a worker receives for a week of unemployment approximates 50 percent of his past weekly wages, but will vary from \$3 to \$25, depending on the State law and on his prior earnings. Benefits are usually payable for not more than from 16 to 26 weeks in a 12-month period called a benefit year.

Prior earnings are not the only condition of eligibility for benefits. The worker must also be unemployed, be able to work and available for work, file a claim for benefits, register for work at a public employment office, serve a waiting period, i. e., a period during which the claimant may not draw benefits, and not be disqualified from benefits under any provision of the State law.

P. 372
to 374

WEEKLY BENEFIT AMOUNT

All but three State laws originally provided a maximum weekly benefit amount of \$15.³ At the present time, 12 States, with 26 percent of the covered workers, provide a weekly maximum of \$24 or more, including allowances for dependents in four of them. Thirty-seven States with 84.8 percent of the covered workers, have a maximum of \$20 or more. A maximum of \$18 or more is provided in 46 States, with 95 percent of the covered workers. Five States, with 5 percent of the workers, provide a maximum weekly benefit amount of less than \$18; and three of these still provide the original \$15 maximum.

P. 375
to 377

Only seven State laws originally provided a fixed minimum weekly benefit amount, which varied from \$5 to \$7.50. Fixed minimums are now provided in all laws except one, and they vary from \$3 to \$10. Seven States have minimums of less than \$5; 16 of \$5; and 28, of more than \$5. Over half the covered workers are in States with minimums of \$7 or more.

At the present time benefits are geared directly in some fashion to past wages. Dependents' allowances, which are provided in five States, depart from a strict relating of benefits to past wages by weighting payments in favor of claimants with family responsibilities. They assume that the claimant with dependents needs larger weekly payments to meet basic living costs than the claimant without dependents.

The proportion of wage loss to be compensated by the program is, largely, a matter of public policy. If the system is to be effective the proportion should not be so small as to require any substantial proportion of beneficiaries to resort to relief while in benefit status, or unduly to depress living standards. However, the proportion should not be so large as to make benefit status more attractive than work. Decisions on the basic weekly benefit amount will be affected by action on dependents' allowances. If dependents' allowances are provided, the proportion of wage loss compensated through the basic benefit would probably be smaller than without dependents' allowances.

P. 388
to 390

Just what the maximum benefit amount should be is again largely a matter of public policy. It seems reasonable to make it high enough so as not to require undue reductions in the living standards of higher-wage beneficiaries. Moreover, as wage rates rise or fall, it would be reasonable to adjust the maximum accordingly. Finally it should not be so low as to produce a substantially flat weekly payment. In 1946 more than 90 percent of the payments in two States were at the maximum, and in nine more this proportion was 80 to 89.9 percent. If this result is produced over a period

³ While the discussion of the benefit structure is in terms of total unemployment, i. e., a complete lack of work and absence of earnings during a specified period, normally a week, many individuals are subject to another type of unemployment, called partial unemployment, which exists when the plants in which they work operate less than full time and which, if prolonged, can produce much the same consequences as total unemployment. At the present time, all States except one compensate for partial unemployment.

of time, benefit payments would not be related to prior wages in the accepted sense, and it would seem more logical to provide flat benefits, thus eliminating the administrative costs involved in maintaining wage records and computing individual benefits.

DURATION OF BENEFITS

The number of weeks for which benefits may be paid in a benefit year, varies in most States in accordance with base-period wages, within specified maximum and minimum limits, although 15 States provide uniform weeks of benefits for all eligible claimants.

P. 377
to 378

All except 3 of the State laws originally limited the maximum duration of benefits to 16 weeks or less, 20 providing less than 16 weeks. Today 40 States, with 87.1 percent of all covered workers, provide a maximum duration of 20 weeks or more. Only 9 States provide a maximum of less than 18 weeks.

Because of the nature of the original duration and weekly benefit amount provisions, it is not possible generally to summarize the original minimum duration provisions. Including 14 of the States which provide uniform duration, 16 States, with 31.3 percent of all covered workers, today provide minimum duration of 14 weeks, or more; 22 States, with 48.7 percent of covered workers, provide from 7 to 14 weeks; and the remaining 13 States provide less than 7 weeks for claimants who barely qualify for benefits.

A decision on length of duration involves basically a decision as to what unemployment compensation is supposed to accomplish, and its place in the totality of public programs designed to provide employment or assistance for the unemployed. In the absence of final decisions on these matters, it is still possible to make some general comments on duration.

P. 390

Duration should obviously not be so short that a large proportion of beneficiaries would normally exhaust their benefit rights. If a large proportion of the beneficiaries were normally required to shift from unemployment compensation to another program for the unemployed, it would seem appropriate to question how the two programs serving substantially the same group could be justified. Assuming effective eligibility conditions, plus financial capacity, it would seem to be unnecessary to limit duration. The actual limit would depend on public policy as to how long benefits should be paid to an individual as a matter of right, without any demonstration of his need, or without his performing any work or training for another job for which work opportunities exist.

POTENTIAL BENEFITS IN A BENEFIT YEAR

The total amount of benefits potentially payable to an eligible claimant in a benefit year is obtained by multiplying the claimant's weekly benefit amount by the number of weeks for which he may be entitled to benefits, or by dividing

P. 378
to 380

base-period wages by the duration fraction. While it is impossible to analyze potential benefits for every eligible claimant it is possible to analyze potential benefits at the maximums and the minimums provided in State laws. It should be recognized, of course, that the States vary widely in the amount of benefits they provide on the basis of the same wages. Thus, average weekly wages of \$30 and base-period wages of \$1,000 would produce potential benefits varying from \$200 to \$500.

At the present time, 33 States, with 80.7 percent of the covered workers, provide at least a maximum of \$20 per week for a maximum of 20 weeks. Forty States, with 89.2 percent of the covered workers, provide at least a maximum of \$18 per week for a maximum of 18 weeks and 11 States pay less than \$18 per week or less than 18 weeks or both. One State pays at the maximum \$15 for 14 weeks and one, \$20 for 12 weeks.

Stated in dollars, 11 States, with 42.5 percent of the covered workers, provide maximum annual benefits of \$546 or more; in two of these States, however, only claimants with a specified number of dependents can receive the maximum amount. Twenty-three States, with 38.5 percent of the workers, provide maximum annual benefits of from \$396 to \$520. Seventeen States, with 19 percent of the workers, provide maximum annual benefits of \$360 or less.

At the present time, the benefits potentially payable to the claimant who qualifies only for the minimum under State laws vary from \$5 to \$260. Thirty-eight States, with 80.2 percent of the covered workers, provide minimum potential benefits of \$50 or more. Thirteen States, with 19.8 percent of the covered workers, provide potential benefits of less than \$50 at the minimum.

The base-period wages required to qualify for minimum potential annual benefits also vary markedly among the States. Six States do not provide any benefits to claimants who earn less than \$300 in base-period wages. At the other extreme, four States provide benefits for claimants with less than \$100 in base-period wages. Thirty-one States require from \$100 to \$200 in base-period wages to qualify.

WAITING PERIOD

A fairly long waiting period was justified initially on two main grounds. One was the belief that financial consideration made it necessary and desirable to limit benefit expenditures for short-term unemployment to conserve funds for prolonged unemployment, and the other was to allow time in which to process initial claims.

All State unemployment-compensation laws originally required a waiting period of at least 2 weeks; 17 required 3 weeks, and 3 required 4 weeks. The majority of States also required additional waiting-period weeks within the benefit year, under specified conditions. Experience over the years has indicated that relatively long waiting periods are un-

P. 381

necessary either for administrative reasons or for fund protection, and States have accordingly reduced them so that no State requires more than two initial weeks; 41 States require only 1 initial week, 32 of them a week of total or partial unemployment; and 1 State, Maryland, eliminated its waiting period altogether in 1945.

ELIGIBILITY CONDITIONS

All laws contain eligibility conditions which an individual must meet before he is entitled to receive benefits. Benefits are limited to individuals who have worked in covered employment. Wages in such employment are normally used to reflect such work. If an individual has worked in covered employment for a sufficient time to have qualifying wages, he must, as a further condition for entitlement to benefits, be unemployed, either totally or partially. Since unemployment compensation compensates for wage loss from unemployment due to economic causes, individuals must be able to work and be available for work. Ability to work is generally understood to mean physical and mental capacity for work, and availability, to mean attachment to the active labor force. There are, of course, wide differences of opinion on the meaning of ability to work and availability for work in specific and concrete situations.

Individuals are required to register for work at a public employment office, because such an office provides the only general machinery for determining ability to work and availability for work. The individuals are also required to file an initial claim, which certifies to the beginning date of a period of unemployment. The requirement for periodic reporting (usually weekly) gives the State agency an opportunity to examine the claimant more closely as to his ability to work, availability for work, and other circumstances surrounding his claim for benefits.

P. 382

DISQUALIFICATION FROM BENEFITS

An otherwise eligible individual may not actually receive benefits, at least for a specified period, because of the circumstances surrounding his unemployment. Thus, a worker may be disqualified from receiving them if (1) he has left work voluntarily without good cause; (2) he has been discharged for misconduct in connection with his work; (3) he has failed, without good cause, either to apply for suitable work or to accept suitable work when offered him; or (4) his unemployment is due to a labor dispute.

Disqualifications are intended to prevent payment of benefits to an individual whose unemployment is a result of his own voluntary behavior. Most disqualifications take the form of a postponement of benefits; others take the form of both a postponement of benefits and a reduction or cancellation of benefit rights. During the past few years the trend has been to expand disqualification provisions so as to restrict the rights to benefits of individuals subject to them.

P. 383
to 387
and
P. 391

This expansion has taken several forms, such as (1) increasing the length of disqualification, (2) canceling or reducing benefit rights, and (3) altering the definition of disqualifying acts. Since 1945 changes made in the three major disqualification provisions appear to have altered the restrictive trend evident in prior years.

In 23 States, disqualification for all three causes now takes the form of postponement of benefits for a limited period only. Twenty-four States provide for cancellation or reduction of benefit rights for one or more of the three disqualifications, and 13 for all three causes. However, in four of these States cancellation or reduction is discretionary with the administrator of the State law. Five States disqualify for the duration of the unemployment for all three causes and seven additional States for one or two of the disqualifying reasons. In a period when few jobs are available, disqualification for the duration of the unemployment may mean a complete denial of benefits. This result is true also of provisions which completely cancel benefit rights.

On the subject of disqualifications considerable disagreement exists. In justification of present restrictive disqualifications, it is said that liberalization of benefit schedules requires the States to exercise more controls over the receipt of benefits. Moreover, many of them were enacted during the war period, when all efforts were being made to induce workers to remain on or to go to essential jobs.

On the other side, it is said that restrictive disqualification provisions conflict with the basic objectives of the system, insofar as it is designed to promote labor mobility, protect labor standards, and maintain purchasing power. It is said that unemployment which originates out of an individual's own actions cannot be attributed to such actions for more than a specified period of time after which it becomes attributable to the state of the labor market rather than commission of the act. Unemployment thus becomes involuntary in character and should be compensated as such, provided, of course, the individual is otherwise eligible. A variable period, depending on the circumstances in each case, of up to 4 to 6 weeks is suggested by many as an appropriate disqualification period.

In addition, it is asserted that the trend toward restrictive disqualifications is in part due to the presence of experience rating in unemployment compensation. Under most experience-rating plan : contribution rates are based on the benefits of former workers which are charged to each employer's record. Hence, it is said, employers are interested in avoiding benefit charges through restrictive disqualifications in order to increase their chances of getting a lower tax rate.

CHAPTER III. COVERAGE OF UNEMPLOYMENT COMPENSATION

As originally passed, the Federal unemployment tax applied to all employers who employ eight or more workers within 20 or more weeks in a calendar year in employment

P. 396
to 398

covered by the act. The employments covered included any service, of whatever nature, performed within the United States, by an employee for an employer, except: (1) Agricultural labor; (2) domestic service in a private home; (3) service performed as an officer or member of the crew of a vessel; (4) service performed by an individual in the employ of his son, daughter, or spouse, and by a child under the age of 21 in the employ of his father or mother; (5) service performed in the employ of the United States Government; (6) service performed in the employ of a State, or its political subdivisions; and (7) service performed in the employ of nonprofit organizations such as, community chests, or foundations organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes. Railroad workers were also excluded when the Congress established a national railroad unemployment insurance system, effective July 1, 1939.

No action was taken by the Congress to broaden to any substantial extent the coverage provided in the original Social Security Act until 1946 when coverage was extended to private maritime employment. Generally speaking, State laws contain the same exclusions as the Federal act, except for employees of small firms.

For the week of August 3-9, 1947, it is estimated that some 34.4 million individuals were protected by unemployment compensation, including 31.4 million under State laws, 1.6 million under the Railroad Unemployment Insurance Act, and 1.4 million under the Servicemen's Readjustment Act. Some 13.6 million wage workers were without such protection. Another 13.3 million self-employed persons in the labor force are not considered within the scope of unemployment insurance for purposes of this report.

EMPLOYEES IN SMALL FIRMS

From the beginning several State laws have applied to employers with less than eight workers. At present, 29 State laws cover employers of less than 8, of which 16 cover employers of 1 or more. P. 398 to 399

Although more than half the unemployment compensation laws now extend to these smaller employers, universal coverage of such employers within the foreseeable future will probably require congressional action. They are already covered by old-age insurance. The administrative feasibility of such coverage has been demonstrated in the States which have administered coverage of one or more.

CIVILIAN EMPLOYEES OF THE FEDERAL GOVERNMENT

Except for the temporary program of unemployment benefits for seamen employed by the United States through the War Shipping Administration, the Social Security Act provides no protection for Federal civilian employees. States, of course, are powerless to bring them under State P. 409 to 420

unemployment compensation laws, without appropriate congressional action.

Involved in any consideration of the extension of unemployment insurance to Federal workers are questions of coverage, benefits, administration, and method of financing. Bills which were introduced in Congress in the last 3 or 4 years include proposals for: (1) a completely Federal system, administered by a Federal agency; (2) payments made in accordance with a uniform national scale of benefits, administered by State agencies; (3) payments made in accordance with the provisions of the law of the State in which the Federal service was performed, administered by State agencies; and (4) payments made in accordance with the law of the State in which the unemployed Federal worker files his claim for benefits, administered by State agencies.

MARITIME WORKERS

Originally no State laws covered maritime services because it was thought that there was a constitutional bar to such coverage. When the Supreme Court decisions in May 1943 on the *Standard Dredging Corporation v. Murphy* and *International Elevating Company v. Murphy* cases altered this situation, maritime service was automatically covered in a few States and subsequently some States repealed the specific exclusion. With the amendment of the Unemployment Tax Act to cover maritime services from July 1, 1946, many States automatically covered these services and others amended their laws to cover them, so that by September 15, 1947, all but eight States⁴ provided some coverage for maritime services.

P. 399
to 409

In addition to extending the coverage of maritime workers in the permanent Federal-State unemployment insurance system, the Social Security Act Amendments of 1946 also provided a temporary Federal program of reconversion unemployment benefits for seamen who were employed by agents of the War Shipping Administration. The Federal program became effective on July 8, 1947, when funds were appropriated to pay the benefits provided in the 1946 law, and will continue through June 30, 1949. As a result of this amendment all State employment security agencies are now paying benefits to these seamen in accordance with the benefit provisions in the State laws.

AGRICULTURAL WORKERS

Agricultural workers were excluded from the Social Security Act in 1935 largely because the collection of the tax on their wages would be difficult. In the Social Security Act Amendments of 1939 the definition of "agricultural labor" was amended so that the exclusion was extended to plants that process agricultural products and transport them to market.

P. 420
to 424

⁴ Arizona, Kentucky, Mississippi, Montana, Nevada, North Dakota, South Dakota, Utah.

Administrative difficulties remain the chief objection to covering agricultural labor, but they do not seem to be insuperable. The problem of collecting contributions might be met by using a stamp book. Deciding when a farm laborer is unemployed and whether he is available for work is one of the responsibilities now faced by States whenever a farm worker, qualified for benefits by nonfarm work in covered employment, claims benefits. Similar decisions could be made if he were covered as an agricultural worker.

DOMESTIC SERVICE

Domestic service in a private home, a local college club, or a local chapter of a college fraternity or sorority is excluded under the Federal Unemployment Tax Act. Only one State, New York, has provided protection to domestic workers in those private homes in which four or more such workers are employed. P. 424 to 430

The exclusion of domestic workers falls principally upon women; over 93 percent of all household employees were women, and household employment constituted the major occupation of 18 percent of the 12.5 million women who were gainfully employed in 1940. The exclusion also falls disproportionately upon Negroes.

NONPROFIT WORKERS

Nonprofit organizations were excluded from the Social Security Act in 1935 without any reason being given for the exclusion. Their workers are also excluded from coverage by State laws, except in Hawaii and Tennessee. P. 430 to 432

The arguments generally given for excluding nonprofit organizations are that their employees are in less need of protection than industrial workers, that the taxes would have to be paid out of charitable donations, and that taxing religious organizations would infringe on religious freedom. In favor of covering nonprofit organizations, it is argued that at least their maintenance and clerical employees are frequently unemployed, that even religious organizations cover their employees with workmen's compensation and other insurance, and that the administrative difficulties of this coverage would be minor.

EMPLOYEES OF STATE AND LOCAL GOVERNMENTS

Although the Federal tax is not applicable to State or local governments in their capacity as employers, several States have extended the protection of unemployment compensation to some of their employees. New York includes almost all State employees. Other State laws cover certain selected groups of public employees, while still others allow election of coverage by political subdivisions.⁵ P. 432 to 435

⁵ Arizona, Idaho, Maryland, Nevada, Ohio, Tennessee, Utah, Washington, and Wisconsin.

State and local government employees are engaged in a wide variety of occupations, some of them stable and others not. It would seem, however, that provision of unemployment compensation for State and local employees is peculiarly a State matter.

CHAPTER IV. FINANCING UNEMPLOYMENT COMPENSATION

BENEFIT FINANCING

For the most part, benefits have been financed from a payroll tax imposed on employers. In line with the suggestion made by the Committee on Economic Security, the Congress made the unemployment tax in the Social Security Act applicable only to employers. At one time or another, nine State laws have required contributions from employees, but only two States—Alabama and New Jersey—now require them.

P. 443
to 449

In the early years of benefit payments considerable concern was expressed as to the ability of State unemployment compensation funds to meet their benefit liabilities. However, because of several circumstances, including the high level of employment during the war period and the inclusion of special war-risk rates in several States, State reserves are, on the whole, adequate to meet benefit payments for any foreseeable future period.

Experience has demonstrated that there are wide differences among States in the rate and duration of unemployment. As a consequence, even if every State had the same benefit structure, benefit costs would likewise vary widely among the States. It seems essential, therefore, that States be permitted to limit tax collections to the amounts necessary to support their benefit needs. At the present time, the only method by which States can limit their collections is by experience rating. At the end of 1946, 45 State laws provided for experience rating. In 1947 another five States adopted it. As a result, there have been sharp reductions in tax rates. In 1946 the average rate for the Nation was 1.4 percent, as compared with the standard rate of 2.7 percent. The average rate in individual States ranged from 0.3 to 2.1 percent.

It has been suggested that States should also be permitted to limit their collections by flat (or horizontal) rate reductions. Flat-rate reductions would apply to all employers alike, in contrast to rates based on the individual employer's experience with unemployment. A flat rate imposed on pay rolls automatically results in high income to the unemployment fund during periods of high employment levels and in reduced income when pay rolls are at a low level. Under existing experience-rating systems, the opposite is true; rates tend to be high during depressions and low during more prosperous periods. A flat rate, moreover, would not penalize new employers.

Whatever the decision as to flat, or horizontal, tax deductions, the requirements that the experience-rating provisions

in State laws must meet now in the Federal Unemployment Tax Act might well be reexamined. The requirements are very difficult to apply to specific provisions in State laws. If experience rating is to be continued, consideration might be given to the appropriateness of revising the requirements so as to give the States more freedom in selecting the type of experience-rating system they want. Still another question is whether or not action should be taken to permit the granting of lower tax rates to newly subject employers.

[Support for reduction in the Federal tax from 3 to 2 percent is provided by estimates that the cost of the program for the country as a whole would average less than 1.5 percent if peak unemployment amounted to less than 10 percent of the civilian labor force and somewhat under 2 percent if unemployment were as high as 20 percent.⁶ Even with such a reduction the offset provisions could be retained.]

A more radical change would involve shifting from the present tax-offset system to a grant-in-aid system. Specifically, a Federal grant-in-aid system would substitute a specified Federal unemployment tax (1 percent has been suggested), without any offset provisions, for the present provision. Out of the proceeds of the Federal unemployment tax the Federal Government would provide a 50-percent Federal grant-in-aid toward the cost of State benefit payments. It is suggested that Federal grants might begin when a State's reserve had declined to one-half of its present size. Since one-half of the cost would be defrayed by the Federal Government, it is said that a State would be as well off with one-half of its present reserve as it now is. Moreover, under this proposal, each State would decide for itself how it would finance its half of the cost. Its cost would be financed out of employer taxes, employee taxes, general taxes, or, for a time, by drawing upon the present reserve. If a State financed its portion of the cost through an employer's tax it could retain employer experience rating or not, as it chose.

P. 455
to 458

The advocates of a grant-in-aid system in connection with unemployment compensation base their proposal in part upon what they consider the relatively favorable experience with it in public assistance and in part upon what they consider to be anomalies, inconsistencies, and complexities in the existing tax-offset system.

Against the proposal it is suggested that this method commits the Federal Government to expenditures that are not needed, because the States have fully adequate funds to finance benefits. Moreover, the potential loss to the States of a share of the proceeds from a relatively small payroll tax collected by the Federal Government might, in extreme cases, not even prevent some States from abandoning altogether their unemployment compensation systems. On the other hand, some States might so liberalize their benefits as to result in a disproportionate flow of Federal funds to them.

⁶ Principles of Cost Estimates in Unemployment Insurance, W. S. Woytinsky, Washington, Government Printing Office, 1947.

ADMINISTRATIVE FINANCING

As was indicated earlier, Federal grants provide the funds to cover all State unemployment-compensation administrative expenses. While a number of considerations influenced the decision to establish this unique arrangement, probably the major factor was the desire of the Congress to insure adequate administrative financing in all States at a time when the Federal Government wished to give every possible incentive to the States to pass laws. The system has now been in operation for more than 11 years.

P. 436

In 1941, the last prewar year, a total of approximately 71 million dollars was spent in administering unemployment compensation and employment service functions in the States. In the year ending June 30, 1947, the comparable total was about 126 million dollars, about 57.6 million dollars for unemployment compensation and 68.4 million dollars for employment services. The substantial increase is due in part to higher salaries, higher prices of supplies and equipment, and, in some areas, higher work loads. An important contributing factor, however, has been an expansion in administrative and staff functions.

It may be pointed out that the 1947 total does not include some \$30,000,000 spent by the States in administering the readjustment allowance program for veterans. In neither year are the expenses of administering Federal functions connected with the program included.

The present method

A primary advantage of the present method is that it provides a national pooled administrative fund for all States. More effective use can be made of such a single pooled fund from which money is allocated among the States, in accordance with their changing needs during the year, than would be possible with 51 separate administrative funds, with no possibility of shifting money from a State where it is not needed to one where it is.

P. 437
to 441

The Congress, which determines the size of the national pool through the appropriation process, has generally made adequate administrative funds available and can be expected to continue to do so, so long as the Federal Government has revenue from the Federal unemployment tax, which, in congressional opinion, is intended for the administrative expenses of the program.

A second advantage is that Federal budgetary procedures offer a way of meeting the rapidly changing needs of a dynamic system like unemployment compensation. Work loads fluctuate widely, both as to totals for all States and in individual States. Since the Congress remains in session almost continuously, it is available to consider deficiency appropriation requests as the need arises. This budgetary method is far more flexible than that of many States. Usually, the amount of money appropriated to a State-financed agency by the average State legislature is fixed for

the year or for the biennium, with little or no provision for supplementary funds in case of need.

In spite of its advantages, the present method has been the subject of considerable criticism. One criticism has been that, with complete Federal financing, the States may not exercise as much care in controlling expenditures as they would if they were responsible, in whole or in part, for raising their administrative funds. Some States have criticized the present method on the grounds that it does not provide adequate funds and that Federal budgeting arrangements do not permit proper planning of State agency operations.

The system, moreover, has created a fertile field for disagreement between Federal and State authorities. The States often express the belief that the funds which they receive are inadequate, that the Social Security Administration discriminates among States in its allocation of funds, and that the Administration exercises too many controls in connection with the granting of funds. On its side, the Administration points to Federal Statutory requirements which State administrative performance must meet in order to qualify for administrative grants. The Administration has taken the position that the Congress looks to it for an accounting of the manner in which a congressional appropriation for administrative grants to States is finally spent. On this assumption it has undertaken to establish controls that, in its opinion, will make reasonably certain that State agencies expend administrative grants carefully and economically.

Despite differences of opinion, Federal and State authorities have worked together to improve the present method. The States now participate in the development of the estimates needed for the annual appropriation request; improvements have been made in the method of allocating funds to States; [and efforts are being made to obtain approval of a contingency fund, which would be used only if work loads exceeded estimates. The establishment of such a fund would introduce additional flexibility into the financing process]. The area of disagreement has been reduced, and there is every prospect that further cooperation will result in additional improvements.

Suggested changes

As a result of criticisms of the present system, however, several suggestions have been made for modifying the method of financing State administration.

One suggestion is that present Federal discretion as to amounts of administrative grants be replaced by some type of statutory formula, based on factors such as State populations, areas, claims loads, etc. The chief difficulty with this approach is in developing an effective and equitable formula and one which would take account of sudden changes in work load.

P. 441

Another suggestion would substitute a grant-in-aid plan for paying administrative costs. Under such an approach, the Federal Government would match State appropriations. State agencies would presumably go before their State legislatures and justify their budgets. The Social Security Administration would then match the funds appropriated by the legislatures. P. 441

This approach would give the States responsibility for determining the amount of funds needed and sharing in the costs of financing administration. To the extent their legislatures permitted, the State agencies would have wider latitude in making expenditures within the limits of the amounts appropriated.

[Another suggestion is that the Federal share of the Federal unemployment tax be earmarked and made available under a continuing appropriation for financing administration. Under this arrangement a designated Federal agency would determine the amounts necessary for administration in each State without specific over-all congressional appropriation. The difference between tax collections and amounts needed for administration could periodically be placed in a loan fund similar to that established by the War Mobilization and Reconversion Act of 1944. Precedent for this type of continuing appropriation in Federal financing may be found in the Railroad Unemployment Insurance Act.⁷

[This proposal would place complete discretion for determining amounts needed by States in the hands of a Federal administrative agency; legislative scrutiny of appropriation requests would then be eliminated.]

The suggestion receiving the most attention is that the offset against the Federal tax be made 100 percent instead of 90 percent, so that the States might collect the 0.3 percent tax now collected by the Federal Government. The States would deposit their collections in their trust funds and then use the trust funds to meet both benefit and administrative costs. Presumably, this approach would require State agencies to go before their legislatures and justify their budgets and obtain their administrative appropriations. If legislatures limited appropriations to the new source of revenue, some State agencies would be inadequately financed. During the year ending June 30, 1947, costs of administering unemployment insurance and employment service functions in 13 States were in excess of Federal collections in those States, which means that a 0.3 percent tax in those States would not have produced enough money to administer the program adequately. As a consequence, proponents of the proposal recommend that appropriations not be so limited. This would mean that in some States reserves originally intended for benefit payments would be used for administration. In any event, complete responsibility for financing would presumably be placed in the States; the Federal Government would retire from the field. P. 442 to 443

⁷ Public Law 346, 78th Cong., 2d sess., sec. 11.

It is difficult to establish a justification for the imposition of a Federal tax which would yield little if any revenue for Federal purposes. The existence of the tax would seem to necessitate the continuation of most, if not all, present tax-collection procedures, including the determination of liability, but the revenue obtained would be limited to collections from employers who, for one reason or another, had not qualified for the 100-percent offset. Moreover, since the Congress would still be basically responsible for the imposition of the tax even if the 100-percent offset were permitted, it seems reasonable to assume that it would continue some controls over the expenditure of the revenue derived from the tax.

Conclusions

Any proposal for altering the present method of financing administrative costs involves a great many considerations, but perhaps the basic ones are that adequate funds be provided and the proper controls be exercised over their expenditure. The question now at issue is as to whether the national interest requires the Federal Government to continue its responsibility for assuring adequate funds and controlling their expenditure, or whether that responsibility shall be given to State legislatures. It seems manifest that this responsibility would not be given to State unemployment compensation agencies themselves, since such an arrangement would give a public spending agency final authority to determine the amount of funds it needed to spend.

PUBLIC EMPLOYMENT SERVICES

The present system of public employment offices is based on the provisions of the Wagner-Peyser Act, approved June 6, 1933. The Wagner-Peyser Act abolished the then existing United States Employment Service and created a new USES as a separate bureau in the Department of Labor. The purpose of the Wagner-Peyser Act was "to promote the establishment and maintenance of a national system of public employment offices." To that end, among other things, the United States Employment Service was directed "to assist in establishing and maintaining systems of public employment offices in the several States and the political subdivisions thereof."

The device provided in the Wagner-Peyser Act for encouraging States to act was the authorization of grants-in-aid to State employment services which affiliated with the United States Employment Service. For this purpose an appropriation of \$1,500,000 was authorized for the fiscal year ending June 30, 1934, and the sum of \$4,000,000 for each of the four succeeding fiscal years, and such sums annually thereafter as the Congress might deem necessary. Federal funds were used to match State appropriations, within specified limits. By 1938 all States had employment services affiliated with the USES.

P. 680
to 681

The passage of the Social Security Act in August 1935 provided the basis for an expansion of public employment offices. It required State unemployment compensation laws to include a provision for the "payment of unemployment compensation solely through public employment offices or such other agencies as the Board may approve." In actual operation the Social Security Administration has approved only public employment offices. The expansion occurred with the beginning of benefit payments in 1938, and was financed with funds made available to the Social Security Board for grants to States for the proper and efficient administration of State unemployment compensation laws. P. 682

With the beginning of benefit payments, two major problems emerged. One of these was the lack of integration and coordination of employment service and unemployment compensation personnel and activities in State and local offices. Integration and coordination were lacking, although employment service and unemployment compensation functions were usually administered by the same overhead agency in the States.

Integration and coordination of the two functions in State agencies was complicated by the fact that the responsible Federal agencies were separate, and this condition constituted the second major problem. The USES was in the Department of Labor; Federal unemployment compensation functions were in the Social Security Board. State agencies were thus required to deal with two Federal agencies on almost all matters affecting their operations. They were receiving their funds for employment service operations from three sources: State and local funds, Wagner-Peyser grants from the Department of Labor, and unemployment compensation administrative grants from the Social Security Board. Their funds for unemployment compensation operations came wholly from the Social Security Board. P. 683

Despite the best efforts of the Federal agencies concerned, confusion continued to exist. Most students of the problem recommended that Federal responsibility for employment service and unemployment compensation functions be placed in one agency. Much testimony on the point was given before the Committee on Ways and Means in 1939. Finally, on July 1, 1939, the USES was transferred from the Department of Labor to the Social Security Administration, by the President's Reorganization Plan No. 1. P. 686 to 693

From July 1, 1939, to December 31, 1941, the USES was administered by the Social Security Board. During this period State agencies generally effected a more complete integration of their unemployment compensation and employment service programs.

On January 1, 1942, the State employment services disappeared as a result of their transfer to the USES, in accordance with a request from the President. The provisions of the Wagner-Peyser Act thus became inoperative as of that date—and the USES became an operating Federal service. The Service was operated by the Social Security Board until P. 685 to 686

September 17, 1942. On that date, it was transferred to the War Manpower Commission where it remained until September 19, 1945. It was then transferred to the Department of Labor, where it is now located.

As the peak in war production passed and increasing attention was given to postwar problems, the States began to express concern as to the return of the employment services. The return of the employment services was a major issue when *Issues in Social Security* was published and the Congress gave much consideration to the matter in 1945 and 1946, but the return was not actually effectuated until November 16, 1946.

The return of the employment services to State control was brought about by provisions in the 1947 Labor-Federal Security Appropriation Act. This act provided for a separate Federal appropriation to meet 100 percent of the expenses of the State services and stipulated that a State need not make any appropriation to match Wagner-Peyser grants until after July 1, 1948. Since November 16, 1946, the employment services have thus been administered by the States, by the same agencies which administer unemployment compensation.

[At the present time Federal employment service and unemployment compensation functions are performed by separate agencies, and the situation existing prior to the 1939 reorganization is practically duplicated. Under the terms of existing legislation, however, the USES is scheduled to revert to the Federal Security Agency 6 months after the termination of the war. On May 5, 1947, President Truman sent Reorganization Plan No. 2 of 1947 to Congress. This plan provided for the permanent retention of the USES in the Department of Labor and thus provided for permanent separation of employment service and unemployment compensation at the Federal level. Hearings were held on this reorganization plan and a joint resolution of both Houses turned it down. While this action may be interpreted to indicate clearly the desire of both the House and the Senate that Federal employment service and unemployment compensation functions should be located in the same Federal agency, the rejection of Reorganization Plan No. 2 did not necessarily indicate what Federal agency should perform them. The House Committee on Expenditures in the Executive Department in its report ⁸ rejecting the plan, however, stated:

The hearings brought out that—

1. The Bureau of the Budget, while favoring the recommendation of the President, indicated that its professional staff differed as to the solution of this organization problem.

2. The Department of Labor's representatives favored the consolidation of the two functions in one agency and expressed the opinion that the Department of Labor could administer more efficiently the two functions than any other agency of the Government because of the related programs having to do with labor statistics and other labor laws.

⁸ Report No. 499, 80th Cong., 1st sess. [to accompany H. Con. Res. 49].

3. The representatives of the Federal Security Agency believed that the administration of the unemployment insurance laws should remain, as at present, related to the administration of social-security laws.

4. The representatives of the State bodies administering these two programs expressed the belief that more efficiency and economy would be obtained by consolidating the two functions. These representatives also expressed the belief that the preferred handling of the organization problem in the Federal Government would be—
(a) Transfer the USES to the Federal Security Agency.

* * * * *

The chief argument of the Federal officials urging the permanent transfer to the Department of Labor was the fear that, in the Federal Security Agency, the job placement function would be subordinated to the payment of unemployment benefits.

No other witnesses concurred in that fear. The fact of the matter is that such subordination would have to take place at the operating level—in the States at any event.

The great weight of the evidence is to the effect that social security activities, which concern all the people—employers, employees, and generally the public—should be consolidated in one central agency. The committee believes that it would be as great a mistake to place the Employment Service under the jurisdiction of the Department of Labor as to place it under the Department of Commerce.

[Although under existing legislation, Federal responsibilities for the employment service are scheduled to revert to the Federal Security Agency 6 months after the end of the war, an issue has arisen as to whether employment service functions should revert to the Federal Security Agency, as scheduled, or whether unemployment compensation functions should be transferred to the Department of Labor. In 1939 the decision was that the two functions appropriately belonged in the Federal Security Agency. The question now arises as to whether the considerations which influenced the decision in 1939 remain valid today.]

CHAPTER V. ISSUES IN UNEMPLOYMENT COMPENSATION

Prior to the advent of the depression of the thirties, assistance for the unemployed was considered generally to be a responsibility of local government. State governments, to say nothing of the Federal Government, were not deemed to have an interest in the problem. Even as late as 1931 only four States provided any aid to the unemployed.

P. 450
to 453

As unemployment climbed from an estimated 1.5 millions in 1929 to 4.2 millions in 1930, to 7.9 millions in 1931, to 11.9 millions in 1932, and to 12.6 millions in 1933, prevailing concepts of governmental responsibility underwent change. The States generally were forced to accept some responsibility for the unemployed. Then, as the problem grew beyond their capacity to handle it, the States and localities turned to the Federal Government.

The Federal Government appeared reluctant to recognize a national interest in aid to the unemployed, but finally such recognition was given. The first step was taken when the Congress, in July 1932, appropriated \$300,000,000 for loans—later canceled—to States and localities for use in meeting the relief problem. Since 1932 the national interest in the prob-

lem of unemployment has manifested itself in widely different programs. Beginning in May 1933, with an appropriation of \$500,000,000 to be used in making direct grants to the States for emergency relief, the Federal Government subsequently spent billions of dollars of Federal funds through various programs for the unemployed, including the Federal Emergency Relief Administration, the Civil Works Administration, the Works Progress Administration, the Civilian Conservation Corps, and the National Youth Administration.

By the middle of 1943 the emergency programs established during the thirties had been discontinued. In the meantime, however, the national long-range interest in providing for the unemployed had been expressed in the unemployment compensation provisions of the Social Security Act, passed in 1935. Later, in 1938, a special Federal system of unemployment insurance was established for railroad workers. In 1944 the Congress expressed the national interest in the unemployment of another special group—the veterans of World War II. This expression of national interest took the form of a provision for readjustment allowances, at Federal expense, for veterans who are unemployed or who fail to earn as much as \$100 per month in self-employment. Again, in 1946, the Congress expressed its interest in another special group—maritime workers who had been employed by the United States through agents of the War Shipping Administration. This expression took the form of a provision for unemployment insurance, at Federal expense, for a temporary period ending June 30, 1949.

In 1946 the Congress also expressed the national interest in another type of unemployment—unemployment due to nonindustrial accident and sickness. It did this by providing a temporary disability insurance program for railroad workers. In 1946, too, the Congress took action to facilitate the enactment of temporary disability insurance laws by the States, by authorizing States which have collected employee contributions to withdraw them to finance temporary disability insurance.

The foregoing indicates the extent to which the Congress has recognized unemployment to be of national concern. It has supported that recognition with billions of dollars for various programs providing emergency relief or work for the unemployed. It has made an important long-range attack on the problem of providing income for the involuntarily unemployed through the unemployment compensation provisions of the Social Security Act. The effectiveness of this attack will substantially affect the extent to which the Congress may be called upon for work relief and other emergency programs in the future. Thus it is of national concern that the Federal-State unemployment-compensation programs for providing income to the unemployed shall be effective systems.

The initial establishment of unemployment-compensation programs is principally attributable to Federal action taken at a time when large relief expenditures were being made.

Up to 1935, the year in which the Social Security Act became law, the efforts of the States to establish programs had been almost completely ineffective. Only one State, Wisconsin, had enacted a law. Judging from experience with other types of social legislation, it seems fair to conclude that, without the Social Security Act, many States would not now have unemployment-compensation laws. Although the Social Security Act did not, in specific terms, require States to enact unemployment-compensation laws, it was intended to encourage them to do so, and its tax offset provisions might be described as compelling.

National interest in unemployment compensation thus inspired Federal action which has resulted in an unemployment-compensation program in every State. The Federal action was, of course, designed to achieve a result—not the mere enactment of State laws, but the creation of a mechanism to aid in solving the problem of unemployment.

The Federal tax coverage in effect insured that certain broad groups would be protected. The connotations of the term “unemployment compensation” prescribed the general approach in providing this protection, as did the requirement of making payments through public employment offices. Beyond this, and some guaranty against misuse of the systems, the development of the programs was left to the States. Thus the amount and duration of benefits, their relationship to past wages, and other matters which determine the effectiveness of the program’s attack on the problem of unemployment have been left to State decision.

The question now arises as to whether the national interest in unemployment compensation requires Federal action beyond the limits established in existing law. The Congress is basically responsible for the imposition of the taxes collected under State unemployment compensation laws. Are the conditions imposed for the receipt of benefits and the amounts payable from the proceeds of these taxes such as to be consistent with the national interest in effective unemployment compensation systems? The benefit structures in the various State programs differ greatly—as to weekly amounts, duration, conditions required to qualify for benefits, and as to reasons for and severity of disqualifications for benefits. The question is whether the resulting protection is nevertheless such that the national interest in unemployment compensation is reasonably satisfied, or whether there are some limitations on benefits so pronounced as to require Federal action in this area, which has heretofore been left largely to State action.

With respect to coverage, the question arises as to whether considerations initially resulting in treating some groups of citizens differently from other groups, when the only essential difference between them is the kind of work they do or the size of the firm in which they work, still prevail, or whether the national interest now requires their coverage.

Questions of Federal action in the field of unemployment compensation have sometimes been discussed in terms of

P. 391
to 395
and
P. 453
to 455

States' rights. Without attempting any evaluation of the historical or emotional aspects of this concept, perhaps it might be generally agreed to mean that, as applied to unemployment compensation, the Federal Government should take no steps other than those required by the national interest. Perhaps it might also be agreed that the Congress must be the judge of what is required in the national interest.

Thus, if the Congress determines that the provisions now contained in the Federal Unemployment Tax Act and the Social Security Act represent the extent of the national interest in unemployment compensation, it will presumably not modify the Federal-State system as it now exists. If it believes that present Federal requirements go beyond the national interest, it presumably will modify the Federal-State system in the direction of eliminating some present Federal requirements and could conceivably withdraw from the field of unemployment compensation altogether. If, however, the Congress believes that present Federal requirements fall short of expressing the national interest, it presumably will modify the Federal-State system in the direction of extending Federal control by introducing additional requirements for States to meet and could conceivably establish a completely Federal system of unemployment compensation.

Any proposal for altering basically the present Federal-State system should be considered in the light of the system's accomplishments. The protection provided by the original State laws has been generally expanded over the years since their enactment in 1935, 1936, and 1937. Speaking generally, weekly benefit amounts have been increased, durations have been extended, waiting periods have been reduced, and in some States new groups, particularly the employees in small firms, have been brought within the scope of the program. The trend has been restrictive only as to the conditions required to qualify for benefits. As a method for protecting workers against wage loss, unemployment compensation is far more effective today than it was in the beginning. Moreover, present methods of administrative financing have been reasonably effective, for new and complicated administrative mechanisms have been established under them which, generally, are now operating efficiently and economically. Finally, reserve funds have been built up which are adequate to meet any foreseeable contingency.

P. 455
to 459

TABLE 5.—Maximum weekly and potential annual benefits, and qualifying wages, for maximum benefits, by State, Sept. 15, 1947

State	Maximum weekly benefit	Maximum weeks of benefits for total unemployment	Maximum annual benefits	Qualifying wages for maximum benefits ¹			
				High quarter		Base period	
				Amount	Fraction	Amount	Fraction or percent
Alabama ²	\$20.00	20	\$400	\$507.01	$\frac{1}{20}$	\$1,200.00	$\frac{1}{20}$
Alaska ³	25.00	25	625	480.01	$\frac{1}{20}$	1,875.00	$\frac{1}{20}$
Arizona	20.00	12	240	380.01	$\frac{1}{20}$	4,600.00	Uniform
Arkansas	20.00	16	320	468.01	$\frac{1}{24}$	8,960.00	$\frac{8}{12}$
California ⁴	25.00	26	650	580.00	$\frac{1}{20}$ – $\frac{1}{23}$	1,300.00	$\frac{1}{20}$
Colorado	17.50	20	350	425.01	$\frac{1}{20}$	1,050.00	$\frac{1}{20}$
Connecticut ⁵	7 24.00–36.00	22	7 528–792	611.00	$\frac{1}{20}$	2,080.00	$\frac{8}{14}$
Delaware ³	18.00	22	396	437.51	$\frac{1}{20}$	1,584.00	$\frac{1}{20}$
District of Columbia ³	9 20.00	20	9 400	437.01	$\frac{1}{20}$	800.00	$\frac{1}{20}$
Florida	15.00	16	240	345.01	$\frac{1}{18}$ – $\frac{1}{24}$	960.00	$\frac{1}{20}$
Georgia ³	18.00	16	288	455.01	$\frac{1}{20}$ – $\frac{1}{26}$	4,720.00	Uniform
Hawaii ³	25.00	20	500	600.01	$\frac{1}{20}$	4,750.00	Uniform
Idaho	20.00	20	400	475.01	$\frac{1}{10}$ – $\frac{1}{24}$	1,820.00	$\frac{8}{40}$ – $\frac{22}{20}$
Illinois ³	20.00	26	520	390.01	$\frac{1}{20}$	1,575.00	$\frac{8}{56}$ – $\frac{33}{20}$
Indiana ³	20.00	20	400	475.01	$\frac{1}{20}$	1,600.00	$\frac{1}{20}$
Iowa	20.00	20	400	460.00	$\frac{1}{20}$	1,200.00	$\frac{1}{20}$
Kansas	18.00	20	360	425.01	$\frac{1}{20}$	1,080.00	$\frac{1}{20}$
Kentucky ¹⁰	16.00	20	320	11 398.75	(11)	4 1,595.00	Uniform
Louisiana ¹⁰	18.00	20	360	425.01	$\frac{1}{20}$	1,440.00	$\frac{1}{20}$
Maine ³	20.00	20	400	11 500.00	(11)	4 2,000.00	Uniform
Maryland	25.00	26	650	637.01	$\frac{1}{20}$	2,600.00	$\frac{1}{20}$
Massachusetts ³	17 25.00	23	13 575	480.00	$\frac{1}{20}$	1,916.66	$\frac{3}{10}$
Michigan ⁶	14 20.00–28.00	20	14 400–560	15 390.13	(15)	15 900.30	15 23
Minnesota ⁴	20.00	20	400	11 437.50	(11)	1,750.00	$\frac{8}{47}$ – $\frac{22}{20}$
Mississippi ¹⁰	15.00	14	210	364.01	$\frac{1}{20}$	4,450.00	Uniform
Missouri ³	20.00	20	400	487.51	$\frac{1}{20}$	1,600.00	$\frac{10}{14}$
Montana	18.00	16	288	388.88	$\frac{1}{22}$	4,540.00	Uniform
Nebraska ³	18.00	18	324	425.01	$\frac{1}{20}$	972.00	$\frac{1}{20}$
Nevada	17 20.00–26.00	20	17 400–520	380.01	$\frac{1}{20}$	1,200.00	$\frac{1}{20}$
New Hampshire	22.00	23	506	11 500.00	(11)	4 2,000.00	Uniform
New Jersey ³	22.00	26	572	462.01	$\frac{1}{22}$	1,716.00	$\frac{1}{20}$
New Mexico	20.00	20	400	494.01	$\frac{1}{20}$	1,000.00	$\frac{2}{5}$
New York ³	18 21.00	18 26	546	471.00	$\frac{1}{20}$	4,630.00	Uniform
North Carolina ³	20.00	16	320	11 520.00	(11)	4 2,080.00	Uniform
North Dakota ³	20.00	20	400	437.01	$\frac{1}{20}$	4,560.00	Uniform
Ohio ³	21.00	22	462	584.00	$\frac{1}{20}$ – $\frac{1}{28}$	10 1,117.31	(20)
Oklahoma ³	18.00	20	360	340.01	$\frac{1}{20}$	1,080.00	$\frac{1}{20}$
Oregon	20.00	20	400	11 400.00	(11)	1,600.00	$\frac{8}{14}$
Pennsylvania ⁶	20.00	24	480	488.00	$\frac{1}{20}$	1,646.00	$\frac{8}{310}$
Rhode Island	25.00	26	650	490.00–600.00	$\frac{1}{20}$	2,400.00	$\frac{8}{52}$ – $\frac{27}{20}$
South Carolina ³	20.00	16	320	494.01	$\frac{1}{20}$	4,800.00	Uniform
South Dakota	20.00	20	400	450.00	$\frac{1}{20}$ – $\frac{1}{23}$	1,800.00	$\frac{8}{48}$ – $\frac{22}{20}$
Tennessee	18.00	20	360	442.01	$\frac{1}{20}$	4,540.00	Uniform
Texas ³	18 18.00	18 18	324	455.01	$\frac{1}{20}$	1,620.00	$\frac{1}{20}$
Utah	21 17.00–25.00	21 20–25	500	380.00–450.00	$\frac{1}{20}$	22 1,800.00	(23)
Vermont ³	20.00	20	400	500.00	$\frac{1}{18}$ – $\frac{1}{26}$	4,600.00	Uniform
Virginia ¹⁰	15.00	16	240	350.01	$\frac{1}{20}$	930.01	$\frac{8}{14}$
Washington ³	25.00	26	650	11 550.00	(11)	2,200.00	$\frac{8}{40}$ – $\frac{29}{20}$
West Virginia ³	20.00	21	420	11 450.00	(11)	4 1,800.00	Uniform
Wisconsin ⁶	24.00	24	576	24 598.13	(24)	24 1,840.40	24 36
Wyoming ³	20.00	20	400	390.01	$\frac{1}{20}$	25 1,560.01	25 14

¹ The amount of high-quarter wages required for the maximum benefit amount varies with the rounding provision as well as with the fraction of high-quarter wages. Rounding is indicated by odd cents regardless of State practice in adding or dropping cents. When 2 amounts are given, the higher amount is required for maximum duration at maximum weekly benefits; the lower amount for maximum weekly benefits. In statement of maximum base-period qualifying wages, rounding of benefit duration to dollar amounts is, ignored. Odd amounts given are from tables of duration. The fraction of high-quarter wages applies between the minimum and maximum amounts. When the State law utilizes a weighted table for the benefit formula, approximate fractions are figured at midpoint of brackets between minimum and maximum. When dependents' allowances are provided, the fraction applies to the lesser benefit. See also footnotes 15 and 24.

² Legislature still in session.

³ No change in 1947.

⁴ The potential duration is uniform for all eligible claimants, and the only requirement for base-period wages is a multiple of the weekly benefit amount specified in the eligibility provision, as 30 in Arizona.

⁵ Assume that wages in the 3 quarters other than high-quarter equal at least one-third wages in high quarter. Duration is lesser of 4 times each quarter of base period in which wages are equal one-third wages in the high quarter or one-third of base-period wages.

Footnotes at top of page 74.

Footnotes continued from page 73.

⁶ Statutory provisions shown will become effective after Sept. 15, 1947: California and Michigan, benefit years beginning on and after Jan. 1, 1948; Connecticut, Apr. 14, 1948; Pennsylvania, benefit years beginning on and after Oct. 1, 1947; Wisconsin, determinations which include 1 or more credit weeks ended after 1947.

⁷ \$24 maximum basic benefit plus \$3 per dependent up to one-half basic benefit.

⁸ Maximum potential benefits according to table of base-period wages. Fractions approximate. In Idaho, Illinois, Pennsylvania, and Virginia duration rounded to weekly benefit amount.

⁹ Same maximum with or without dependents; below maximum, weekly benefits equal one-twenty-third of high-quarter wages plus \$1 for each of not more than 3 dependents, and annual benefits may be increased accordingly.

¹⁰ No session in 1947.

¹¹ Utilizes annual rather than high-quarter formula; amount shown is one-fourth of the annual wage required.

¹² \$25 maximum basic benefit plus \$2 for each dependent, total not to exceed average weekly wage. Maximum augmented payment to an individual with dependents not shown, since highest average weekly wage may be \$231 and any figure presented would be based on an assumed maximum number of dependents.

¹³ Weeks of duration for claimants with dependents decreased, since potential benefits are the same whether or not a claimant has dependents.

¹⁴ Basic benefit is 64 to 67 percent of average weekly wage, \$20 maximum basic benefit plus \$2 per dependent up to 4 according to table but not more than 78 to 92 percent of average weekly wage.

¹⁵ Requirements are in terms of average wages with the employer whose account is being charged. Figures given are based on an "average weekly wage" of \$30.01 and all earnings from 1 employer. Duration is full benefit amount times two-thirds number of credit weeks earned with employer.

¹⁶ 8-quarter base period.

¹⁷ \$20 maximum basic benefit amount plus \$2 for each dependent up to 3.

¹⁸ Converted from days of unemployment in New York and 2-week periods in Texas.

¹⁹ For 25 calendar weeks if high quarter represents 13 calendar weeks of employment.

²⁰ 18 weeks' duration for those employed 20 calendar weeks in base period; 19 weeks' duration for those employed 21 to 24; 22 weeks for those employed more than 24.

²¹ Weekly benefit amounts adjusted with cost-of-living index; statutory maximum of \$20 reduced 20 percent when index is 98.5 or below, increased 20 percent when index is at or above 125; maximum annual benefits not affected; therefore under present upward adjustment of weekly benefit amount, weeks of duration are decreased to 20 from maximum potential duration of 25 weeks at \$20 maximum.

²² Requirements are in terms of the average annual State wage of \$1,800 effective for the uniform benefit year beginning July 1, 1947.

²³ Maximum potential benefits determined from a weighted schedule of base-period wages vary in accordance with the percentage relationship of the claimant's base-period wages to average annual State wage.

²⁴ Requirements are in terms of average weekly wages with employer whose account is being charged. Figures given are based on an "average wage" of \$46.01 and all earnings from 1 employer. Duration is in terms of three-fifths of credit weeks with the employer but not more than 40 weeks with 1 employer counted.

²⁵ Fraction of base-period wages rounded to nearest \$20.

Source: Bureau of Employment Security, Social Security Administration.

TABLE 6.—Minimum weekly benefits and qualifying wages therefor, and potential annual benefits and duration of benefits for claimants who meet minimum qualifying requirements, by State, Sept. 15, 1947

State	Minimum weekly amount	Minimum weeks of benefits for total unemployment ¹	Potential annual benefits	Qualifying wages for minimum benefits ²		
				High quarter	Base period	Formula ³
Alabama ⁴	\$4.00	10	\$40.00	\$75.01	\$120.00	30×
Alaska ⁵	8.00	8	64.00	37.50	150.00	Flat.
Arizona	5.00	¹ 12	60.00	37.50	150.00	30×
Arkansas	5.00	⁶ 4	⁶ 20.00	37.50	150.00	30×
California ⁷	10.00	⁸ 15	150.00	75.00	300.00	(⁹)
Colorado	6.00	10	60.00	45.00	180.00	30×
Connecticut ⁷	¹⁰ 8.00-12.00	⁸ 8+	¹⁰ 70.00-106.00	60.00	240.00	Flat.
Delaware ⁸	7.00	11	77.00	52.50	210.00	30×
District of Columbia ⁸	¹⁰ 6.00-9.00	⁸ 12+	¹⁰ 75.00-114.00	37.50	150.00	25×-\$250. ¹²
Florida ⁸	5.00	7+	37.50	37.50	150.00	30×
Georgia ⁸	4.00	¹ 16	64.00	48.00	100.00	25-40×
Hawaii ⁸	5.00	¹ 20	100.00	37.50	150.00	30×
Idaho	10.00	10	100.00	150.00	250.00	25-37+×
Illinois ⁸	10.00	⁸ 12+	125.00	56.25	225.00	Flat.
Indiana ⁸	5.00	⁸ 12+	62.00	75.00	250.00	Do.
Iowa	5.00	6+	33.33	25.00	100.00	20×
Kansas	5.00	6+	34.00	50.00	100.00	Flat.
Kentucky ¹³	5.00	¹ 20	100.00	50.00	200.00	Do.
Louisiana ¹³	3.00	7+	23.00	22.50	90.00	30×
Maine	6.00	¹ 20	120.00	75.00	300.00	Flat.
Maryland	6.00	10	60.00	156.00	240.00	40×
Massachusetts ⁸	¹⁰ 14 6.00-10.00	⁸ 7+	45.00	37.50	150.00	Flat.
Michigan ⁷	¹⁰ 6.00-7.00	9+	¹⁰ 56.00-66.00	(¹³)	112.14	14 weeks. ¹⁶
Minnesota ⁸	7.00	12	84.00	50.00	200.00	Flat.
Mississippi ¹³	3.00	¹ 14	42.00	22.50	90.00	30×
Missouri ⁸	¹⁶ 5.00	1+	5.00	5.00	20.00	40×
Montana	7.00	¹ 16	112.00	52.50	210.00	30×
Nebraska ⁸	5.00	⁸ 13+	67.00	50.00	200.00	Flat.

See footnotes at end of table, p. 75.

TABLE 6.—Minimum weekly benefits and qualifying wages therefor, and potential annual benefits and duration of benefits for claimants who meet minimum qualifying requirements, by State, Sept. 15, 1947—Continued

State	Minimum weekly amount	Minimum weeks of benefits for total unemployment ¹	Potential annual benefits	Qualifying wages for minimum benefits ²		
				High quarter	Base period	Formula ³
Nevada.....	¹⁰ \$8.00-14.00	10	¹⁰ \$80.00-140.00	\$80.00	\$240.00	30×
New Hampshire.....	6.00	¹ 23	138.00	50.00	200.00	Flat.
New Jersey ⁴	9.00	10	90.00	37.50	150.00	Do.
New Mexico.....	5.00	12	60.00	78.00	150.00	30×
New York ⁵	¹⁷ 10.00	¹ 26	260.00	100.00	300.00	Do.
North Carolina ⁶	4.00	¹ 16	64.00	32.50	130.00	Flat.
North Dakota ⁶	5.00	¹ 20	100.00	35.00	140.00	28×
Ohio ⁴	5.00	18	90.00	40.00	160.00	Flat. ¹⁸
Oklahoma ⁵	6.00	6+	40.00	30.00	120.00	20×
Oregon.....	10.00	7+	75.00	75.00	300.00	Flat.
Pennsylvania ^{5 7}	8.00	9	72.00	60.00	240.00	30×
Rhode Island.....	10.00	5+	52.00	25.00	100.00	Flat.
South Carolina ⁴	4.00	¹ 16	64.00	30.00	120.00	30-40×
South Dakota ⁴	6.00	⁸ 10	60.00	60.00	125.00	Flat.
Tennessee.....	¹⁷ 5.00	¹ 20	100.00	50.00	125.00	25-30×
Texas ⁸	¹⁹ 5.00	⁸ 3+	18.00	22.50	90.00	18×
Utah.....	¹⁹ 5.00-7.00	⁸ 25-17+	125.00	63.00	252.00	(20).
Vermont ⁵	6.00	¹ 20	120.00	50.00	180.00	30×
Virginia ¹³	5.00	6	30.00	25.00	100.00	20-25×
Washington ⁸	10.00	12	120.00	75.00	300.00	Flat.
West Virginia ⁸	8.00	¹ 21	168.00	75.00	300.00	Do.
Wisconsin ⁷	8.00	8+	68.00	(15)	140.00	14 weeks. ¹⁵
Wyoming ⁸	7.00	5+	40.00	70.00	175.00	25×

¹ "U" indicates uniform potential duration for all eligible claimants.

² Where high-quarter wages are not specified in the law, base-period wages are divided by the number of quarters in which they must be earned. Formula in terms of multiple of weekly benefit amount indicated. See companion table for high-quarter formula.

³ Distribution of base-period wages required as follows: In 1 quarter \$75.01 (Alabama), \$156 (Maryland), \$78 (New Mexico), \$60 (South Dakota), \$50 (Tennessee and Vermont), \$70 (Wyoming); wages in 2 quarters (Arizona, Connecticut, Florida, and Georgia); \$150 in 1 quarter and wages in 2 quarters (Idaho); \$150 in last 2 quarters (Indiana); \$100 in 2 quarters or \$200 in base period (Kansas); wages in 3 quarters of 8-quarter base period (Missouri).

⁴ State legislature still in session.

⁵ No change in 1947.

⁶ Duration is the lesser of 4 weeks for each quarter of the 4-quarter base period in which the claimant's wages are equal to at least one-third his high-quarter wages or one-third of base-period wages. Therefore, if all or the largest part of the qualifying wage was earned in 1 quarter, the potential annual benefits are \$20. If one-third high-quarter wages were earned in each other quarter, the total potential benefits would be one-third of the qualifying amount or \$50.

⁷ Statutory provisions shown will become effective after Sept. 15, 1947; California and Michigan, benefit years beginning on and after Jan. 1, 1948; Connecticut, Apr. 4, 1948; Pennsylvania, benefit years beginning on and after Oct. 1, 1947; Wisconsin, determinations which include 1 or more credit weeks ended after 1947.

⁸ In States which have a flat dollar qualifying requirement, if the qualifying wages are concentrated largely or wholly in the high quarter, the weekly benefit may be higher than the minimum and the weeks of benefits for such a claimant with minimum qualifying wages would be less than the weeks of benefits here shown at the minimum benefit amount for minimum qualifying wages.

⁹ Greater of \$300 and one-third of high-quarter wage in the other 3 base-period quarters or 30 times the weekly benefit, whichever is lesser.

¹⁰ Higher figure includes dependents' allowances.

¹¹ \$200 if 75 percent of an individual's wages are in seasonal industry; i. e., in first processing of agricultural products; such individual's benefits are not payable during period November through April.

¹² 25 times up to weekly benefit of \$10; above that amount, flat \$250.

¹³ No session in 1947.

¹⁴ The augmented payment shown assumes that the average weekly wage is \$9.23 which by statute is raised to the next highest dollar. Dependents' allowance of \$2 per dependent (total payment not to exceed average weekly wage) will not increase maximum annual benefits and hence will decrease weeks of benefits for claimants with dependents.

¹⁵ 14 weeks of employment are needed to qualify computations based on employment with 1 employer. In Michigan benefits are two-thirds of credit weeks and lowest average weekly wage to qualify is \$8.01; in Wisconsin benefits are three-fifths of credit weeks and lowest average weekly wage to qualify is \$10.

¹⁶ Minimum weekly benefit is 50 cents, but if less than \$3, total benefits are paid at rate of \$3 per week.

¹⁷ Converted from days of unemployment in New York and 2-week periods in Texas.

¹⁸ And employment in at least 20 weeks.

¹⁹ Cost-of-living provision raises weekly benefit amount 20 percent, rounded to next higher dollar, when cost-of-living index reaches 125. Since total annual benefits are not increased, duration is decreased. Therefore, under present upward adjustment of minimum benefit to \$7, weeks of duration are decreased to 17 from potential duration of 25 weeks at \$5.

²⁰ 14 percent of average annual State wage which is \$1,800 for the benefit year beginning July 1, 1947, and the higher of \$150 or 150 percent of high-quarter wages.

Source: Bureau of Employment Security, Social Security Administration.





A REPORT

to

**THE SECRETARY OF
HEALTH, EDUCATION, AND WELFARE**

on

**Extension of Old-Age and Survivors
Insurance To Additional Groups
Of Current Workers**

CONSULTANTS ON SOCIAL SECURITY

WASHINGTON : 1953

CONTENTS

	Page
Letter of Transmittal.....	v
Membership of the Consultant Group.....	vi
Introduction and Summary.....	1
Extension of Coverage.....	8
1. State and Local Government Employees Under Re- tirement Systems.....	8
2. Self-Employed Professional Persons.....	10
3. Self-Employed Farm Operators.....	10
4. Hired Farm Workers.....	11
5. Domestic Workers.....	14
6. Ministers and Members of Religious Orders.....	15
7. Employee Fishermen Not Now Covered.....	17
8. Home Workers.....	18
9. American Seamen Employed on Foreign-Flag Vessels by American Employers.....	18
10. Extension of "Free" Wage Credit Provisions for Mem- bers of the Armed Forces.....	19
11. Revised Method of Computing the Average Monthly Wage.....	20
Appendix A. Employment Categories for Which No Recom- mendations Are Made.....	23
Appendix B. Cost Estimates for Universal Coverage.....	24

LETTER OF TRANSMITTAL

June 24, 1953.

HON. OVETA CULP HOBBY,
Secretary of Health, Education, and Welfare,
Washington 25, D. C.

DEAR MRS. SECRETARY:

When you asked us to serve as consultants on social security, you referred to the President's recommendation in his State of the Union Message on February 2 that the "old-age and survivors insurance law should promptly be extended to cover millions of citizens who have been left out of the social-security system." The paragraph of the State of the Union Message in which that recommendation appears is:

"There is urgent need for greater effectiveness in our programs, both public and private, offering safeguards against the privations that too often come with unemployment, old age, illness, and accident. The provisions of the old-age and survivors insurance law should promptly be extended to cover millions of citizens who have been left out of the social-security system. No less important is the encouragement of privately sponsored pension plans. Most important of all, of course, is renewed effort to check the inflation which destroys so much of the value of all social-security payments."

As requested by you, we have given consideration in our study of social security to various alternatives for extending old-age and survivors insurance to additional groups of current workers, both employed and self-employed. In this study we have all served as individuals and the proposals contained in this report do not necessarily reflect the views of any organization with which any consultant may be connected.

There is transmitted herewith a report which includes the proposals which we have developed for your consideration in carrying out the President's recommendation for extending old-age and survivors insurance.

Respectfully submitted.

REINHARD A. HOHAUS,
Chairman, Consultants on Social Security.

MEMBERSHIP OF THE CONSULTANT GROUP

Mr. Reinhard A. Hohaus, Vice President and Chief Actuary,
Metropolitan Life Insurance Company, Chairman

Mr. Thomas H. Beacom, Vice President in Charge of Trusts,
First National Bank of Chicago

Dr. Eveline M. Burns, Economist and Professor of Social Work,
New York School of Social Work, Columbia University

Mr. Robert P. Burroughs, President and Treasurer of R. P.
Burroughs Company, Pension and Profit Sharing Plans

Mr. Leonard J. Calhoun, Attorney at Law

Mr. Nelson H. Cruikshank, Director of Social Insurance Activities,
American Federation of Labor

Mr. Wallis B. Dunkel, Vice President, Bankers Trust Company

Miss Loula Dunn, Director, American Public Welfare Association

Mrs. Katherine Ellickson, Secretary, Social Security Committee,
Congress of Industrial Organizations

Mr. Hugh F. Hall, American Farm Bureau Federation

Dr. Lloyd C. Halvorson, The National Grange

Mr. A. D. Marshall, Manager of Employee Benefits, General Elec-
tric Company

EXTENSION OF OLD-AGE AND SURVIVORS INSURANCE TO ADDITIONAL GROUPS OF CURRENT WORKERS

INTRODUCTION AND SUMMARY

As requested by Secretary Hobby, we have given consideration to various alternatives for extending old-age and survivors insurance to additional groups of current workers, both employed and self-employed. It is our understanding from the Secretary that the President wishes us to give our considered collective opinion, respecting each question involved, as individual citizens from varied backgrounds. Our conclusions, therefore, should not be interpreted as those of any organizations with which any of us are connected.

In evaluating the possibility of including each additional group of current workers not now included, we have considered first of all the question of technical feasibility. This has involved consultation with representatives of the Bureau of Internal Revenue as to the practical difficulties with respect to each separate group in collecting the necessary tax and with representatives of the Bureau of Old-Age and Survivors Insurance regarding the practical aspects of determining both eligibility and benefit amount for the groups in question.

We have, however, been forced to recognize that the distinction between what is technically feasible and what is fair, socially desirable, and in the public interest is useful mainly as a device for breaking down the broad subject of social security into divisions that lend themselves to separate study. In actual practice, the various phases and aspects of social insurance such as coverage, benefits, and financing are not separable. In complying with the request that we make recommendations regarding extension of coverage, it has not been possible for us to make a study of certain other features of the old-age and survivors insurance program, the existence of which means that the present plan falls short in certain respects of providing all the various advantages which a contributory old-age and survivors insurance system can have for the country. The objectives of this program as we understand it are:

- (a) Inclusion of all workers, employed and self-employed;

- (b) Payment of benefits related to prior earnings and as a matter of right without a needs test; and
- (c) Financing on a contributory basis.

We have operated on the premise that participation in the old-age and survivors insurance program will prove of real benefit to the members of most groups of current workers and that broader participation therein will be in the public interest. We have, therefore, tried to take into account the question of fairness, justice, and consistent treatment for each group considered, no matter how small the group or what initial difficulties would have to be overcome in administering the program for that group. Beyond this, we have operated on the principle that the solutions chosen should be directed toward (1) maintaining the long-established standards of honesty and objectivity in regard to individual reports and benefit rights; (2) minimizing the possibility of abuses that might undermine public confidence in the old-age and survivors insurance program; and (3) extending coverage on a basis which will not adversely affect the protection of those now covered.

In summary, we might identify our method of approach by stating that with respect to each group we have asked ourselves this question: "Taking into account all problems involved, and the broad lines of policy which the President has indicated he wishes to follow, is it our best judgment that an effort *should* be made to include *this* group?"

* * * * *

Under the coverage provisions of the Social Security Act as originally enacted, about six out of ten paid civilian jobs were included. Subsequent amendments to the Social Security Act, including the major revisions made in 1950, extended coverage so that now about eight out of ten paid civilian jobs are included. Although there has been at least one cogent reason why each group of excluded workers has been left out in the past, we believe that it is feasible at this time to extend coverage to most of the jobs now excluded.

Several of the groups for whom we recommend coverage do not raise any particular administrative or technical difficulty not already encountered under present coverage. Coverage for State and local government employees under retirement systems, self-employed professional persons, fishermen, and home workers is almost entirely a matter of policy rather than administrative or technical feasibility. Coverage of some of the other groups does present certain difficulties but we believe these can be overcome in the ways which we suggest in the report. The groups which present some special, but not insuperable, problems include self-

employed farm operators, hired farm workers, and domestic workers.

On the other hand, our recommendations for extension of coverage at this time do not include the blanketing-in of persons already age 65 or over who because they have not become eligible through prior work in covered employment are not receiving insurance benefits. We have excluded this group from consideration in this report because their inclusion would involve very substantial modifications of the present program which would require careful and prolonged study.

Since special studies were initiated last year by Congress in regard to the relationship of the old-age and survivors insurance program to the Railroad Retirement Act and to Federal employee retirement systems, we have not included in this report any recommendations with respect to railroad workers or to employees of the Federal Government and its instrumentalities who are currently excluded. The study of the railroad retirement program and its relation to old-age and survivors insurance was undertaken by the Joint Congressional Committee on Railroad Retirement, established by S. Con. Res. 51 of the Eighty-second Congress. The relation of old-age and survivors insurance to the Federal employee retirement systems is being studied by a Committee on Retirement Policy for Federal Personnel, consisting of the Secretary of the Treasury, the Secretary of Defense, the Chairman of the Board of Governors of the Federal Reserve System, the Director of the Bureau of the Budget, and the Chairman of the Civil Service Commission, with a Chairman (Mr. H. Eliot Kaplan) appointed by the President. This Committee was authorized by Public Law 555, Eighty-second Congress. Because of these special studies, we are making no proposals at this time concerning railroad workers and none for Federal employees other than one that the "free" wage credits now provided for members of the armed services be extended for a temporary period. It is urgent that this proposal for a limited extension of the \$160 "free" wage-credit provision receive early consideration, since the present provision expires at the end of this year. There are no special technical problems connected with this proposal. Finally, in order to complete the report as speedily as possible, we have not given consideration to a few special employment categories listed in Appendix A, and accordingly no recommendations are made for them in this report.

* * * * *

We have included in the report a proposal (Number 11) for revising the method for computing the average monthly wage to provide that the three years in which earnings credits were the

lowest (or nonexistent) would ordinarily be disregarded but in no case shall the period over which the average monthly wage is computed be less than the period of time required for the worker to obtain fully insured status.

Our proposal is designed to meet the problem of the newly covered groups, who under existing legislation would in many instances have substantially lower benefits than those already covered because they do not have wage credits in 1951, 1952, and 1953. Our proposal solves this problem of the newly covered groups as part of an overall improvement in the program. It represents a recognition that for the long run the present average monthly wage provision results in reductions in the benefit amount for every year a worker is out of the system. Unemployment or disability for even part of a year can now cause benefit reductions. For example, to get maximum benefits a worker must now be paid at least \$3,600 in every year after 1950 or his twenty-second birthday, whichever is later. Any year in which he earned less would result in his getting a benefit lower than the \$85 maximum.

By making possible the payment of full-rate benefits where earnings were reduced or nonexistent in as many as three years, the proposal does away with the need for any special provision for the newly covered groups. At the same time it gives to those already covered the advantage of some future protection against the lowering of the average monthly wage because of periods of unemployment, disability, or low earnings. For newly covered persons with no prior quarters of coverage the three years prior to 1954 will be omitted from the computation since such persons will not have had covered earnings in those years; any subsequent years with little or no earnings will count against them. For persons now covered who contributed on earnings in years prior to 1954, on the other hand, up to three years (past or future) in which they have little or no earnings will be omitted from the computation. This recognizes the longer period during which such persons have been under the system.

Our proposal solves the immediate problem arising from extension of coverage. We recognize, however, that it may be desirable for the long run to allow individuals who have been under the program for a considerable period of time to disregard more than three years in computing the average monthly wage. This is particularly important because the groups brought under coverage after 1953 will in general be unable to utilize the three-year provision to offset future periods of low earnings or absence from the system. We are not intending by our present recommendation to prejudice later consideration of broader proposals designed to solve the long-range problem of the adverse effect of periods of low earnings or absence from the system on monthly benefits.

It will be noted that we have not recommended a new start for newly covered groups similar to what was done in 1950. While we think such an arrangement would probably be practical if coverage were extended to substantially all workers now excluded we believe that our proposal is superior to the alternative of a series of new starts.

* * * * *

We have not included in this report any recommendations relative to the retirement test. We recognize that extension of coverage will increase the number of anomalous situations which are created by the existing retirement test and, to this extent, intensify the need to find a more satisfactory retirement provision. However, this problem, like the question of benefit levels and methods of financing, raises broad questions relating to the system as a whole, whatever its coverage, and lies beyond the specific subjects we were asked to consider.

Nor have we included any recommendation for changing the definition of "wages," designed to include remuneration (such as tips) other than that paid an employee directly by his employer. However, we recognize that in certain employments the definition contained in the present law omits a part of the remuneration of some workers. We have confined our report to recommendations relating to categories of workers. Legislation aimed at coverage with all remuneration included would need to take into account those types of payment not now considered "wages."

* * * * *

Appendix B contains cost estimates for the present old-age and survivors insurance program and for the program expanded to include virtually all gainful employment, prepared by Robert J. Myers, Chief Actuary, Social Security Administration. On the basis of the intermediate cost estimates shown in the appendix, universal coverage without other changes in the system would result in a reduction of about 0.4 in the percentage of payrolls required over the years to meet the costs of old-age and survivors insurance. Comparative figures for the extension of coverage that we propose (we have made no recommendation for coverage of additional categories of Federal civilian employment or for coverage of military service beyond a limited extension of present provisions for "free" wage credits) show a reduction of 0.25 percent of payroll over the years.

The saving occurs first of all because under limited coverage, those who move in and out of covered employment have low average monthly wages in covered employment and receive the advantage of a formula weighted in favor of those with low average wages (the benefit formula is 55 percent of the first \$100 of average

monthly wage but only 15 percent above). Under extended coverage, their wages in covered employment will be greater. This means a corresponding increase in contribution income from those persons and their employers, with some but proportionately smaller increase in benefit outgo. This, in turn, means that over time the contribution income will increase more than benefit outgo. Second, extension of coverage means that there will be fewer cases in which earnings from uncovered employment are disregarded in applying the retirement test.

Our proposal for a change in the method of computing the average monthly wage will, on the basis of the intermediate cost estimate, increase long-range costs by about 0.1 percent of payroll. Thus since our proposals for extension of coverage will save about 0.25 percent it is estimated that on balance our proposals taken together will have no significant effect on the percentage of payroll required to meet the costs of the old-age and survivors insurance program.

Summary

In accordance with the President's policy to extend old-age and survivors insurance coverage, we recommend the following:

1. Allow coverage under Federal-State agreements of members of State and local government retirement systems under provisions requiring that all members of a coverage group be brought in if any are covered.

2. Cover self-employed professional persons on the same basis as other self-employed now covered and cover internes by deleting the present exclusion of services of internes in the definition of employment.

3. Cover farm operators on a basis consistent with that on which other self-employed are now covered.

4. Cover cash wages earned in hired farm work regardless of the number of days the individual works for a single employer, and remove the exclusion of workers employed in cotton ginning and the production of gum naval stores.

5. Cover cash wages of domestic workers regardless of the number of days the individual works for a single employer.

6. Allow coverage for ministers and members of religious orders (other than those who take a vow of poverty) on a basis similar to that on which other employees of nonprofit organizations may now be covered.

7. Cover employees engaged in fishing and similar activities who are now excluded.

8. Cover home workers in States without licensing laws on the same basis as those in States with licensing laws.

9. Cover American citizens employed on vessels of foreign registry by American employers on the same basis as other American citizens working outside the United States for American employers.

10. Extend for a limited period the present provision giving "free" wage credits of \$160 a month for service in the armed forces.

11. Revise the method for computing the average monthly wage to provide that the three years in which earnings credits were the lowest (or nonexistent) would ordinarily be disregarded, but in no case shall the period over which the average monthly wage is computed be less than the period of time required for the worker to obtain fully insured status.

EXTENSION OF COVERAGE

1. State and Local Government Employees Under Retirement Systems

Allow coverage under Federal-State agreements of members of State and local government retirement systems under provisions requiring that all members of a coverage group be brought in if any are covered.

We believe that the retirement systems of State and local governments, which now cover about 3.3 million workers,¹ perform for Government as employer the same functions as nongovernmental plans perform for private industry and charitable organizations by attracting and holding good employees and, on the other hand, by making it feasible to retire individuals when appropriate. These functions of State and local systems are not accomplished by old-age and survivors insurance alone, but old-age and survivors insurance coverage need not interfere with these functions where the State retirement systems are retained and are appropriately integrated with old-age and survivors insurance.

The extension of old-age and survivors insurance to employees of State and local government retirement systems would close two major gaps in the protection now afforded such persons—the lack of adequate survivor protection and the lack of continuity of protection for those who move in and out of Government service. Probably about four-fifths² of the persons covered under State and local retirement systems lack adequate survivor protection. Moreover, existing State and local staff retirement systems are designed primarily for those who continue in the service of a particular unit until retirement; the majority of those who leave the service before retirement age normally forfeit any right to retirement income they may have acquired and merely receive a refund of their own accumulated contributions.³ Similarly, persons who enter State and local government employment from private industry may lose all or part of the protection they have acquired under old-age and survivors insurance. The extension of old-age and sur-

¹ Survey of retirement coverage of State and local government employees in the last pay period of October 1952, conducted for the Bureau of Old-Age and Survivors Insurance by the Governments Division, Bureau of the Census. The figure of 3.3 million includes 3 million workers actually covered by retirement systems and 300,000 workers who, though not themselves covered, are in positions covered by retirement systems and therefore cannot be covered by old-age and survivors insurance.

² Estimated by the Bureau of Old-Age and Survivors Insurance on the basis of partial data for State and local retirement systems.

³ Information furnished by the Bureau of Old-Age and Survivors Insurance.

vivors insurance to such Government employment would fill these gaps in present protection.

When coverage is extended to State and local employees who are members of staff retirement systems, those systems can be adjusted to supplement the basic old-age and survivors insurance benefits. It has been demonstrated in private systems that such adjustments can be made satisfactorily and without loss in total retirement protection. Since the old-age and survivors insurance program has been established many hundreds of employee retirement systems of private employers and nonprofit organizations have been made supplementary to old-age and survivors insurance without loss of total retirement protection for the employees concerned. In many cases the protection of employees previously covered under retirement plans in private industry and in nonprofit employment has been considerably increased as a result of the extension of old-age and survivors insurance and the continuance of the private plans on an adjusted basis.

While constitutional barriers preclude the Federal Government from imposing an old-age and survivors insurance employer contribution upon State and local governments on a compulsory tax basis, coverage has been made available to certain employees of State and local governments on a contributory basis through Federal-State agreements. At the present time the Federal statute permits Federal-State agreements covering employees of the States or localities who are not in positions covered by a retirement system but it bars the States and localities from bringing in employees who are in such positions. We believe that the Federal law should be changed in order to permit the coverage of these employees as well.

There are two views as to whether, in making coverage available to employee groups who are under public retirement systems, it is appropriate that the Federal Government leave the decision to bring these employees under old-age and survivors insurance to the State and local governments alone, or whether the Federal Government should require that the decision of the State or local government be subject to the concurrence of the employees concerned. Those consultants holding the view that concurrence of the employees should be required believe that the concurrence should be expressed by a substantial majority of those voting. All are agreed that any provision for covering State and local employees should be on a basis that all members of a coverage group be brought in if any are covered.

We recognize that certain groups of State and local employees such as policemen and fire fighters feel that because there are hazardous and special requirements connected with their work

recognition has been accorded these factors in existing retirement plans. Therefore they hold that there should be no extension of old-age and survivors insurance to their groups. In any case a mandatory Federal exclusion limited to these special groups would be preferable to the continued prohibition of coverage for all State and local employees under existing retirement plans.

2. Self-Employed Professional Persons

Cover self-employed professional persons on the same basis as other self-employed now covered and cover internes by deleting the present exclusion of services of internes in the definition of employment.

Present law specifically excludes the following professions from the definition of trade or business in connection with self-employment: Accountants (with some exceptions), architects, chiropractors, Christian Science practitioners, dentists, funeral directors, lawyers, naturopaths, optometrists, osteopaths, physicians, professional engineers, and veterinarians. Many if not all of these exclusions were made at the request of the groups excluded.

There are no special administrative or technical problems involved in extension of coverage to these self-employed persons which are not already encountered in the present coverage of other professional self-employed persons.⁴ We propose that coverage be extended to persons in the professional groups now excluded on the same basis as other nonfarm self-employed are covered. Thus anyone with annual net earnings of \$400 or more from covered self-employment, including all professional self-employment, would be included. About half a million or so self-employed professional persons would be covered in the course of a year.⁵ These professional persons would report their earnings for social-security purposes annually with their income-tax reports, as is done by the self-employed people now covered.

As a corollary to the inclusion of medical practitioners, we propose that the specific exclusion of services of internes in the definition of employment be deleted.

3. Self-employed Farm Operators

Cover farm operators on a basis consistent with that on which other self-employed are now covered.

We propose that farm self-employment be covered on a basis consistent with the provisions now covering other self-employment. This would be accomplished by removing from the definition of "net earnings from self-employment" the present exclusion of income "derived from any trade or business in which, if the trade

⁴ Although most professional groups are now excluded, a few—writers, artists, actuaries, psychologists, and so forth—are now covered.

⁵ Estimate made by the Bureau of Old-Age and Survivors Insurance on the basis of unpublished data of the National Income Division, Department of Commerce.

or business were carried on exclusively by employees, the major portion of the services would constitute agricultural labor." Thus anyone with annual net earnings of \$400 or over from self-employment, including the operation of a farm, would be covered.

We are advised that in the course of a year about 5 million self-employed persons are covered by present law and that over 3 million farm operators would be covered by this proposal.⁶

Under the provisions now in effect for coverage of nonfarm self-employed persons, the individual, in computing his net income from self-employment on which his benefits are based, must compute his business expenses. This is required for income-tax purposes, also. In computing net income for social-security purposes the individual is required to follow the same rules, regulations, and definitions as he follows for income-tax purposes. Unless some special provision were made for farm operators, the same procedure would have to be followed by farm operators in computing their income for social-security purposes.

Many farm operators, however, do not have an income-tax liability because after deducting expenses and other deductions from gross income their net income does not exceed their personal and dependents' exemptions. Since their exemptions would have no application for social-security purposes, such farm operators would become liable for the self-employment tax. It would be desirable, therefore, to develop a simplified procedure which could be used by the small-farm operator.

One possibility would be to permit a farmer who meets prescribed conditions to report his income from self-employment for social-security purposes as some fixed percentage (say 50 percent) of his gross receipts from farming. Under this proposal anyone wishing to report his actual expenses in computing his net income would be permitted to do so.

We believe that the details of some such simplified method of reporting should be worked out by the Department of Health, Education, and Welfare and the Treasury Department in consultation with the Department of Agriculture.

4. Hired Farm Workers

Cover cash wages earned in hired farm work regardless of the number of days the individual works for a single employer, and remove the exclusion of workers employed in cotton ginning and the production of gum naval stores.

Under present law, in order to be covered a farm worker must be "regularly employed" by one employer and receive cash wages

⁶ The 3 million figure includes almost all farmers who are actually in the business of farming and who derive the major part of their support from farm self-employment. Estimates made by the Bureau of Old-Age and Survivors Insurance on the basis of data from the 1950 Census of Agriculture and the 1949 Consumer Income Survey of the Census Bureau.

of \$50 or more in a calendar quarter from that employer. The definition of "regularly employed" is complicated and difficult to apply. In general, after a farm worker has worked for one employer continuously for an entire calendar quarter, he is "regularly employed" in succeeding quarters if he works for that employer on a full-time basis on at least 60 days during the quarter. Records must be kept over a substantial period before it is clear whether or not an individual is covered. In our opinion the "regularly employed" test is an unnecessary complication.

The elimination of this test would result in the course of a year in covering farm wages for about 2.7 million workers who do not now have their farm wages included.⁷ Moreover, some of the farm workers now covered would have additional wages included if this proposal were adopted.

To get the widest possible coverage under old-age and survivors insurance it would also be necessary to eliminate the \$50 cash wage test in the present law. Such a minimum cash wage test is included only for hired farm workers, domestic workers, and a few smaller categories and does not apply to other employees covered under the system. In principle we believe the elimination of such a test is desirable for all categories of employees. A cash wage test of \$50 related to work for a single employer excludes some workers who would benefit from coverage and also prevents some workers now covered from getting credit for all the wages they have earned. To obtain coverage for all agricultural workers who would benefit therefrom would therefore require the elimination of the cash wage test as well as the time tests.

The major problems concerning the elimination of the cash test relate to the administration of the necessary benefit and tax collection provisions, with the attendant necessity for securing the correct names, account numbers and amounts of wages for agricultural workers hired for only brief periods, and the consequent increase in the reporting burden on the farm employer. The Treasury Department has assured us that it believes it would be possible to secure substantial enforcement of the reporting requirements even if the cash test as well as the time tests were eliminated and has indicated that enforcement would be strengthened if some simplification is made in the present system of wage reporting. It has pointed out, however, that administrative costs would be lower if a wage test were retained. In the opinion of the Treasury Department there would be some advantages in adopting a cash wage test based on a shorter period than a calendar quarter. A

⁷ Estimated by Bureau of Old-Age and Survivors Insurance on basis of data from Bureau of Agricultural Economics, Survey of the Hired Farm Working Force, 1951.

weekly or monthly test would reduce the period during which an employer had to keep records to determine whether a worker is covered or not. On the other hand, there are many situations in which an employer will know at the time of hire whether a worker will be paid a total of \$50 in a quarter.

Since in principle we believe that all agricultural workers should be covered, we urge the Department of Health, Education, and Welfare and the Treasury Department to continue their exploration, in consultation with the Department of Agriculture, of possible methods of accomplishing this objective in the near future without undue burden on the employer.

Under present law workers employed in cotton ginning and in the production of turpentine and other gum naval stores are defined as engaging in "agricultural labor" and are specifically excluded from coverage. Cotton ginning is essentially a commercial service which farmers use in processing their cotton. Many of the owners of the gins are independent businessmen without any farm connections, some are farm cooperatives, some are farm operators who gin only the cotton they produce, and others are farm operators who, in addition to ginning their own cotton, gin cotton for others as a commercial business. The effect of the exclusion of workers who produce gum naval stores is that workers (including sales and administrative workers) employed by a manufacturer of turpentine are not covered by old-age and survivors insurance if the manufacturer produces at least 50 percent of the crude gum processed. We believe that the specific exclusions of these two groups of employees should be eliminated and that the workers should be brought under old-age and survivors insurance. No special administrative or technical problems would be involved in covering these two groups.

The law also excludes from coverage workers from Mexico who are brought to the United States under contract for agricultural work under the Agricultural Act of 1949. While the provisions under which these workers are brought to the United States expire at the end of 1953, they may be extended. The consultants are divided on what should be done in that event.

One group of consultants believes that employers of foreign contract workers in agriculture should be required to pay the same tax as they would if United States citizens or residents were employed, even though the workers themselves may not be required to pay a tax and may not be entitled to benefits. This group believes that the social security program should be designed so as to prevent its providing an incentive to employ such contract workers in preference to United States workers. These consultants further believe that such an incentive would arise from extension of coverage to

farm workers unless employers of foreign contract workers were required to pay the same tax on the wages paid foreign contract workers as on those paid to domestic workers. Others believe that imposition of the employer tax on employers of foreign contract workers, without giving the workers social-security credit, is a matter extraneous to extension of social-security coverage and therefore is a matter which should not be considered by the consultants.

5. Domestic Workers

Cover cash wages of domestic workers regardless of the number of days the individual works for a single employer.

Under present law, in order to be covered, a household worker must work for a single employer on each of 24 days during a calendar quarter and must be paid at least \$50 in cash for such services. In general, under this provision a household worker is covered if she works regularly for a single employer on at least two days a week. In our opinion, the day test is an unnecessary complication.

Elimination of the day test would bring under the program somewhere between 100,000 and 200,000 persons in addition to the somewhat less than a million covered under present law, and would also mean additional coverage for perhaps 50,000 to 100,000 workers who are now covered on some but not all of their jobs.⁸

To get the widest possible coverage under old-age and survivors insurance it would also be necessary to eliminate the \$50 cash wage test in the present law. Such a minimum cash wage test is included only for domestic workers, hired farm workers, and a few smaller categories and does not apply to other employees covered under the system. In principle we believe the elimination of such a test is desirable for all categories of employees. A cash wage test of \$50 related to work for a single employer excludes some workers who would benefit from coverage and also prevents some workers now covered from getting credit for all the wages they have earned. To obtain coverage for all domestic workers who would benefit therefrom would therefore require the elimination of the cash wage test as well as the time tests.

The major problems concerning the elimination of the cash test relate to the administration of the necessary benefit and tax-collection provisions, with the attendant necessity for securing the correct names, account numbers, and amounts of wages for domestic workers hired for only brief periods, and the consequent increase in the reporting burden on the employer. The Treasury Department has assured us that it believes it would be possible to secure substantial enforcement of the reporting requirements, for domes-

⁸ Estimated by Bureau of Old-Age and Survivors Insurance on basis of data from unpublished survey of domestic workers included in the current population sample of the Bureau of the Census, June 1951.

tic workers as well as farm workers, even if the cash test were eliminated. However, it believes that administrative costs would be lower if a wage test were retained. In the opinion of the Treasury Department there would be some advantages in adopting a cash wage test based on a shorter period than a calendar quarter. A weekly or monthly test would reduce the period during which an employer had to keep records to determine whether a worker is covered or not. On the other hand, there are many situations in which an employer will know at the time of hire whether a worker will be paid a total of \$50 in a quarter.

Since in principle we believe that all domestic workers should be covered, we urge the Department of Health, Education, and Welfare and the Treasury Department to continue their exploration of possible methods of accomplishing this objective in the near future without undue burden on the employer.

6. Ministers and Members of Religious Orders

Allow coverage for ministers and members of religious orders (other than those who take a vow of poverty) on a basis similar to that on which other employees of nonprofit organizations may now be covered.

Approximately 190,000⁹ ministers are excluded from old-age and survivors insurance coverage at any one time. This figure includes not only pastors of churches but also ministers who are employed in other capacities (teaching and administration, for example) by religious organizations or pursuant to an assignment by a church. In addition there are about 150,000¹⁰ members of religious orders excluded.

In the past, proposals for coverage of ministers have been considered in the context of compulsory coverage, and many religious organizations were opposed to compulsory coverage of ministers. Many, if not most, such organizations probably would not oppose coverage being made available on a voluntary basis, such as we propose, similar to that on which lay employees of religious organizations may now be covered. Under our proposal coverage would be available to ministers on election by the proper administrative unit of the religious organization and by two-thirds of the ministerial employees.

We believe that the lay employees of a religious organization should be allowed coverage even though the organization does not desire to cover its ministers. On the other hand, an organization should not be permitted to cover its ministers unless its lay em-

⁹ Number of pastoral clergymen estimated by Bureau of Old-Age and Survivors Insurance on basis of 1950 Population Census Data. Number of nonpastoral clergymen estimated by Bureau of Old-Age and Survivors Insurance on basis of data in National Council of Churches, *Yearbook of American Churches*, 1951.

¹⁰ Estimated by Bureau of Old-Age and Survivors Insurance on basis of data in *National Catholic Directory*, 1952.

ployees are also covered. We believe that the Department of Health, Education, and Welfare and the Treasury Department should consult the various denominations on the details of the coverage provisions for ministers as employees.

We are not now recommending coverage for members of religious orders who are required to take vows of poverty. (Most members of monastic and other religious orders are required to take such vows.) We believe that the Department of Health, Education, and Welfare and the Treasury Department should consult with the denominations involved and give further consideration to the question of whether coverage should be made available to this group. Many of the members of religious orders receive no cash remuneration for their services, and the Bureau of Internal Revenue has ruled for income-tax purposes that even if payment is made for services of a member who has taken a vow of poverty, the payment is not his personal income but is income of the order. Thus if coverage were to be extended to this group it would have to be on the basis of a presumed income. Moreover, the members of religious orders frequently live in communal homes where the older members receive support and continue to perform whatever duties they can.

We are not now recommending coverage of self-employment income which clergymen derive for the performance of religious duties. This, too, seems to us a matter for further exploration by the departments and the denominations.

Under present provisions of law applying to lay employees of religious organizations, once an organization and two-thirds of the employees have elected coverage all new employees of the organization must be covered. There are two views as to how new ministerial employees of an organization which has elected coverage should be treated. One view is that the rule applying to lay employees should be applied to ministers also, on the ground that to do otherwise would permit voluntary election of coverage by the individual ministers. Under a program such as old-age and survivors insurance, which in many cases, especially in the early years and for workers with large families, pays benefits considerably in excess of the value of contributions, the opportunity for individual voluntary coverage is likely to have serious effects on the financing of the program if made available to any large number of people. The group of consultants which holds the view that on this point the rule applying to lay employees should be applied to ministers also is opposed in principle to individual voluntary coverage and does not believe it should be provided for ministers.

The other view is that if any class of individual is to be allowed to elect to stay outside of old-age and survivors insurance coverage this freedom to choose should be extended to ministers and its

effectiveness should not be affected by transfer from one congregation to another. Resistance to coverage on the part of some ministers is considered by them to be a matter of principle. To meet this latter view it has been proposed that if a minister elected to be covered, he would be covered whenever he worked for an organization that had also elected coverage. A minister who had not elected coverage would not be covered no matter what action his employing organization had taken. Those holding this view point out that in any case the minister would not have the election to come into the system unless the employing organization has similarly elected.

7. Employee Fishermen Not Now Covered

Cover employees engaged in fishing and similar activities who are now excluded.

Most fishermen are now covered under old-age and survivors insurance either as employees or as self-employed persons. Of the 160,000 ¹¹ or so people engaged in fishing and similar activities, however, about 30,000 ¹² employees are excluded because they are not employed on vessels of more than ten net tons and are not engaged in the catching of halibut or salmon for commercial purposes. Some of the excluded employees work on the smaller vessels; others perform services, such as clam digging, which do not require them to serve on vessels. ¹³ When old-age and survivors insurance was extended to most employee fishermen in 1939, the Congress excluded these groups at the request of certain employers, primarily employers in the shrimp industry. In 1950 the employers of these workers were themselves brought under old-age and survivors insurance as self-employed persons.

We have been advised that most of the fishermen now excluded from coverage work on a share arrangement, as do most fishermen who are now covered. We are also advised that many fishermen are engaged during part of the year in fishing activities covered by old-age and survivors insurance and part of the year in fishing that is not covered. ¹⁴ It appears that the evaluation of a fisherman's share of the catch for social-security purposes should present no problems peculiar to the group working on the smaller vessels. We are not aware of any other technical or administrative reasons for the continued exclusion of this group.

¹¹ Fish and Wildlife Service, Department of the Interior: *Fishing Statistics of the United States*, 1949.

¹² Estimate made by the Bureau of Old-Age and Survivors Insurance on the basis of data from the Fish and Wildlife Service, Department of the Interior.

¹³ The exclusion in question reads as follows: "Service performed . . . in . . . the catching, taking, harvesting, cultivating, or farming of any kind of fish, shellfish, crustacea, seaweeds, or other aquatic forms of animal and vegetable life . . . except (A) service performed in connection with the catching or taking of salmon or halibut, for commercial purposes, and (B) service performed on or in connection with a vessel of more than 10 net tons . . ."

¹⁴ Information furnished by the Bureau of Old-Age and Survivors Insurance.

8. Home Workers

Cover home workers in States without licensing laws on the same basis as those in States with licensing laws.

Home workers who have the status of employees under the usual common-law rules applicable in determining employer-employee relationship are covered in all States. At present home workers in States with licensing laws who do not have employee status under usual common-law rules are also considered employees for purposes of coverage under old-age and survivors insurance if they meet the following conditions:

1. that the work be performed at home according to specifications of the person for whom it is performed;
2. that the work be performed on materials or goods furnished by such person;
3. that the worker be paid cash wages of \$50 or more during a calendar quarter for his services for the particular employer;
4. that the services as a home worker be subject to licensing requirements under State law.

Only 15 States have licensing laws. Moreover, since some of the State licensing laws are not generally applicable to all home workers, even home workers meeting the other conditions listed above for coverage as employees are not necessarily covered as employees in those States.

We propose that home workers in States without licensing laws be covered on the same basis as those in States with licensing laws, so that employee coverage will be extended to home workers who meet the other conditions for coverage now in the statute, irrespective of the State in which the individual is located. If the \$50 quarterly cash wage test now imposed as a condition of coverage of domestic and farm workers is removed, we would propose that it also be removed from the above conditions for home workers. Home workers who would not have employee coverage would continue to be subject to the self-employment coverage provisions on the same basis as other self-employed persons.

9. American Seamen Employed on Foreign-Flag Vessels by American Employers

Cover American citizens employed on vessels of foreign registry by American employers on the same basis as other American citizens working outside the United States for American employers.

The 1950 amendments extended old-age and survivors insurance coverage to most United States citizens working outside the United States for American employers. The law as it existed prior to the 1950 amendments, however, excluded from coverage seamen work-

ing outside the United States on vessels of foreign registry, and, possibly through an oversight, this exclusion was not amended, so that the provision covering American citizens who work outside the United States for American employers did not extend coverage to American seamen working for American employers on vessels of foreign registry. While there are few people affected by this exclusion, it would seem desirable to remove the exclusion and treat all American citizens employed outside the United States on a consistent basis.

The definition of "American employer" now contained in present law, which would be applied in determining coverage on vessels of foreign registry, includes an individual who is a resident of the United States, a partnership if two-thirds or more of the partners are residents of the United States, a trust if all of the trustees are residents of the United States, or a corporation organized under the laws of the United States or any State. The only seamen who would be covered would be those employed by such "American employers." We are advised by the Treasury Department that there are no special problems of tax jurisdiction or administration involved in this proposal.

10. Extension of "Free" Wage Credit Provisions for Members of the Armed Forces

Extend for a limited period the present provision giving "free" wage credits of \$160 a month for service in the armed forces.

Members of the armed forces are now given "free" wage credits of \$160 a month for service any time after September 16, 1940, and prior to January 1, 1954. We believe that this temporary provision should be extended pending a permanent solution of the problem of old-age and survivors insurance coverage for the armed forces.

Old-age and survivors insurance coverage for this group on a mandatory contributory basis is now under consideration by two separate Committees. The Committee on Retirement Policy for Federal Personnel, consisting of the Secretary of the Treasury, the Secretary of Defense, the Chairman of the Board of Governors of the Federal Reserve System, the Director of the Bureau of the Budget, and the Chairman of the Civil Service Commission, with a Chairman (Mr. H. Eliot Kaplan) appointed by the President, is making a study of "all retirement systems for all Federal personnel" (including the military retirement systems) and their relation to old-age and survivors insurance. A Special Committee on Survivors' Benefits, representing each of the four services in the Department of Defense, has recommended to the Director of Personnel Policy in the Department that the armed services be brought

into old-age and survivors insurance coverage, but the Department has not yet taken a position on the question. We believe that consideration of permanent contributory coverage of the armed forces should await the results of the studies of these two groups. We propose as an interim measure, pending a plan for contributory coverage, an extension of the "free" wage credits for a limited period.

11. Revised Method of Computing the Average Monthly Wage

*Revise the method for computing the average monthly wage to provide that the three years in which earnings credits were the lowest (or nonexistent) would ordinarily be disregarded but in no case shall the period over which the average monthly wage is computed be less than the period of time required for the worker to obtain fully insured status.*¹⁵

Our proposal is designed to meet the problem of the newly covered groups, who under existing legislation would in many instances have substantially lower benefits than those already covered because they do not have wage credits in 1951, 1952, and 1953. Our proposal solves this problem of the newly covered groups as part of an overall improvement in the program. It represents a recognition that for the long run the present average monthly wage provision results in reductions in the benefit amount for every year a worker is out of the system. Unemployment or disability for even part of a year can now cause benefit reductions. For example, to get maximum benefits a worker must now be paid at least \$3,600 in every year after 1950 or his twenty-second birthday, whichever is later. Lower earnings in any year would cause his monthly benefit to fall below the \$85 maximum.

By making possible the payment of full-rate benefits where earnings were reduced or nonexistent in as many as three years, the proposal does away with the need for any special provision for the newly covered groups. At the same time it gives to those already covered the advantage of some future protection against the lowering of the average monthly wage because of periods of unemployment, disability, or low earnings.

For newly covered persons with no prior quarters of coverage the three years prior to 1954 will be omitted from the computation since such persons will not have had covered earnings in those years; any subsequent years with little or no earnings will count against them. For persons now covered who contributed on earn-

¹⁵ Because the provisions for the self-employed are on an annual basis it may be desirable to make certain technical modifications of this general proposal. One possibility would be to introduce an exception to the idea that disregarding the three years should not bring the period over which the average is computed below the period of coverage necessary for acquiring fully insured status. The exception would be that where the period required is not a multiple of one year it would be reduced to the next lower multiple of one year providing that in no case would the period be reduced below two years.

ings in years prior to 1954, on the other hand, up to three years (past or future) in which they have little or no earnings will be omitted from the computation. This recognizes the longer period during which such persons have been under the system.

If, for example, an individual who is newly covered in 1954 with no earnings reported for 1951, 1952, and 1953 retires in January 1957, having earned \$3,600 during each of the years after 1954, his three years of no earnings after 1950 would be disregarded and he would become eligible for the \$85 maximum benefit. At the same time, an individual who contributed on earnings in the years prior to 1954 would also benefit through the disregarding of the lowest three years. An example is that of an individual with reported earnings of \$3,600 from 1951 through 1956 who becomes disabled in 1957 and reaches 65 in 1960. If, in the first year of his disablement, he earned less than \$3,600 and was unable to work at all in 1958 and 1959, the last three years would be disregarded. He would thus be eligible for the \$85 maximum at age 65.

Our proposal solves the immediate problem arising from extension of coverage. We recognize, however, that it may be desirable for the long run to allow individuals who have been under the program for a considerable period of time to disregard more than three years in computing the average monthly wage. This is particularly important because, as indicated, the groups brought under coverage after 1953 will in general be unable to utilize the three-year provision to offset future periods of low earnings or absence from the system. We are not intending by our present recommendation to prejudice later consideration of broader proposals designed to solve the long-range problem of the adverse effect of periods of low earnings or absence from the system on monthly benefits.

Dropping out the lowest three years will ordinarily leave a period of at least several years over which to compute the average monthly wage. For example, a person who attains age 65 at the beginning of 1971 would, under present law, have his average wage computed over at least the period of 20 years from the new start date of January 1951 through 1970. Thus, the dropping out of three years would leave a 17-year period over which the average was computed. However, some persons retiring in the near future may, under present law, have their benefits based on a period as short as one and a half years. To drop out three years in such cases would leave no period at all over which to compute the average. Some limitation on the dropping out of three years is therefore needed. We are proposing a limitation such that in every case the average monthly wage would be computed over a period at least as long as that required for the attainment of insured status.

Our proposal would result in dropping out less than three full years in computing retirement benefits only in the case of persons who will attain age 65 before 1957. For all persons who reach age 65 in 1957 or thereafter, three years could be disregarded without reducing the period over which the average wage is computed to less than that required for attaining insured status. On the other hand, a person who attained age 65, let us say, in January 1955 would need the equivalent of two years of coverage in order to be insured. In computing his average monthly wage from the 1951 starting date, since two of the four elapsed years must be retained, only two years may be disregarded.¹⁶

We have been advised by the Bureau of Old-Age and Survivors Insurance that although it would not be practical to recompute individually benefits for the over 5 million persons now on the rolls for the purpose of dropping out the lowest three years of earnings, our proposal is practical for future benefit computations.

¹⁶ The limitation on the dropping out of three years will have a continuing effect in the average wage computation for the purpose of survivor benefits in the relatively few cases where death of the insured worker occurs before age 27.

APPENDIXES

APPENDIX A. Employment Categories for Which No Recommendations Are Made

In order to complete the report as speedily as possible, the consultants have not given consideration to extension of coverage to the following special employment categories now excluded, and accordingly no recommendations are made for them in the report.

Students and Student Nurses

Services performed by a student or student nurse for the school, college, university, or hospital in which he is enrolled and domestic services performed in local college clubs or local chapters of fraternities or sororities by students are specifically excluded from old-age and survivors insurance coverage.

Family Employment

The 1939 amendments exclude service performed by an individual in the employ of his son, daughter, or spouse, and service performed by a child under 21 in the employ of his father or mother.

Employees of Foreign Governments

The United States Government, of course, cannot impose the employer tax of the program on a foreign government. The exclusion of the employees of foreign governments from compulsory coverage must therefore be continued.¹⁷

Newsboys Under Age 18

The present law excludes newsboys under age 18 whether they work as employees or as self-employed news vendors.

Alien Residents of the United States Working for American Employers in Foreign Countries

Citizens of the United States working for American employers in foreign countries are covered by old-age and survivors insurance, but alien residents of the United States working under the same conditions are not.

Service for International Organizations

Employees performing service for international organizations entitled to certain privileges under the International Organizations Immunities Act are excluded from coverage.

¹⁷ We have been informed that the Department of Health, Education, and Welfare and the State Department are exploring the possibility of covering by voluntary agreement United States citizens employed in this country by foreign governments.

APPENDIX B. Cost Estimates for Universal Coverage ¹⁸

New cost estimates for the present old-age and survivors insurance program have just recently been developed to take into account the considerable change in economic conditions during the last few years and the additional actuarial and statistical data available from operating experience and from the 1950 census. These cost estimates have been expanded so as to present data on the cost of the present benefit provisions with universal employment coverage. These cost estimates are based on assumptions of continued high employment and also of level earnings (somewhat below the present levels in both instances).

Estimates of future costs of the old-age and survivors insurance program are influenced by many factors difficult to determine. Accordingly, underlying assumptions may well differ widely and yet be reasonable. Among the many assumptions used, the following are perhaps the most important:

(a) *Mortality*.—Mortality rates by age have been improving steadily since the turn of the century for both sexes and for virtually all ages up to age 60. Although there was relatively little change above that age during the first four decades, during the past decade there has been significant improvement. In the low-cost assumptions, some improvement in mortality rates at all ages is assumed. However, in the high-cost assumptions, considerably more improvement is assumed.

(b) *Retirement Rates*.—The program has been in effect too short a time to give completely conclusive evidence as to probable future retirement rates. Since relatively little is known on this subject from a long-range standpoint, the estimates are based on two widely different assumptions so as to indicate the range of possibilities. These assumptions, however, have been based to a certain extent upon the actual claims data developing over the past few years. Under the low-cost estimate, after a period of years it develops that about 60 percent of the men age 65–69 and 80 percent of the women of those ages who are eligible to receive benefits would actually draw them by reason of ceasing substantial covered employment. For the high-cost estimate, the corresponding figures are 75 percent for men and 90 percent for women. For ages 70–74 the proportions are correspondingly higher, while, of course, beyond age 75 all eligible persons may receive benefits regardless of employment. In the early years all these figures are materially lower since more of those eligible have recently been in employment and thus would be more likely to continue to work.

¹⁸ Prepared by Robert J. Myers, Chief Actuary, Social Security Administration.

(c) *Employment*.—The estimates of future costs assume that the general level of employment will be relatively high, although somewhat below conditions prevailing at the end of 1952.

(d) *Earnings Level*.—The estimates are based on level earnings assumptions slightly below the present levels. If in the future the earnings level should be considerably above that which now prevails, and if the benefits for those on the roll are at some time adjusted upward so that the annual costs relating to pay roll will remain the same, then the increased dollar outgo resulting will offset the increased dollar income. This is an important reason for considering costs relative to pay roll rather than in dollars. Under the assumptions used, with the \$3,600 maximum wage base, four-quarter male workers have average earnings of \$2,980 per year, while for women the corresponding figure is \$2,030.

Further details as to the mortality and other demographic assumptions may be obtained from *Actuarial Study No. 33*, while a forthcoming *Actuarial Study* will give more details in regard to the cost estimates themselves and the various assumptions made.

It should be emphasized that the universal coverage assumed for the purpose of the cost estimates given in this memorandum goes beyond the proposals being made in this report. If coverage were extended only as far as definitely recommended by the consultants (or in other words not to the armed forces or Federal civilian employees under a retirement system), the cost estimates therefor would lie roughly midway between those shown for present coverage and those for universal coverage.

The cost estimates for expanded coverage have been based on the assumption that some provision would be made for removing the handicap of the newly covered groups as to the method for computing the average monthly wage, and thus the benefit amount. Although such a provision would probably not be limited exclusively to the newly covered groups, it was assumed that it would "wash out" over the long-range future. If, however, a provision is adopted which will have some permanent and long-range effect, there would be some increase in cost over the figures shown in this report. For instance, if the average monthly wage is to be computed as at present except that the three years that have the lowest amount of earnings are eliminated from the computation, the cost shown would be increased somewhat, roughly, in the neighborhood of 0.1 percent of pay roll on a level-premium basis.

One other factor in regard to extension of coverage should be mentioned, namely, that insofar as financial relationships are concerned, railroad employment is now covered by the old-age and survivors insurance system as a result of the Railroad Retirement Act Amendments of 1951. Now all survivor and retirement cases

involving less than ten years of railroad service (as well as some survivor cases with ten or more years of service) are to be paid by the old-age and survivors insurance system. Financial interchange provisions are established such that the old-age and survivors insurance trust fund is to be in the same financial position as if there never had been a separate railroad retirement program. The net effect will probably be a relatively small gain to the old-age and survivors insurance system, since the reimbursements from the railroad retirement system will be somewhat larger than the net additional benefits paid on the basis of railroad earnings. The long-range costs developed here are on the basis that all railroad employment is covered employment. The balance in the fund thus corresponds to the actual situation arising. The contribution and benefit figures, however, are slightly higher (roughly 5 percent) than the actual operating figures will show. This is the case because the figures shown here include both the additional contributions which would have been collected if railroad employment were covered employment, and the additional benefits that would have been paid under such circumstances.

Table 1 compares benefit costs both in dollars and relative to pay roll for present coverage and for universal coverage. The level-premium cost figures are based on two interest rates, $2\frac{1}{4}$ percent (close to the current average for trust fund investments) and $2\frac{3}{4}$ percent so as to show the effect of higher rates (interest rates on which investments are based are rising rapidly, and when the major portion of the fund is reinvested at the end of June 1953, it will probably be at $2\frac{3}{8}$ percent or possibly $2\frac{1}{2}$ percent). In considering the increases in the amount of benefit payments, it should be kept in mind that the covered pay roll is about 25 percent higher under universal coverage than under present coverage. The benefit disbursements over the years under universal coverage would be about 10–20 percent higher than those for present coverage. It would be anticipated that benefit disbursements would not increase proportionately with taxable pay roll. If coverage is broadened, the cost of the program relative to pay roll decreases for two reasons. First of all, under limited coverage those who move in and out of covered employment have low average monthly wages in covered employment and receive the advantage of a formula weighted in favor of those with low average wages (the benefit formula is 55 percent of the first \$100 of average monthly wage but only 15 percent above). Under extended coverage, their wages in covered employment will be greater. This means a corresponding increase in contribution income from those persons and their employers, with some but proportionately smaller increase in benefit outgo. This, in turn, means that over time the contribution

income will increase more than benefit outgo. Second, extension of coverage means that there will be fewer cases in which earnings from uncovered employment are disregarded in applying the retirement test.

On a level-premium basis the reduction resulting from these two factors under universal coverage amounts to about 0.3 percent of pay roll for the low-cost estimate, about 0.6 percent for the high-cost estimate, and about 0.4 percent for the intermediate-cost estimate. The extension of coverage recommended in this report would result in a reduction in the level-premium cost of the program by about 0.25 percent of pay roll on the basis of the intermediate-cost estimates.

Table 2 considers the breakdown of the aged population into those receiving old-age and survivors insurance benefits or being supported by earnings, and all others. This is of significance in considering proposals for extending coverage and for "blanketing-in" the current aged. The figures which have been developed are based in large part upon the previous cost estimates, although certain other estimates had to be made which are somewhat tentative and preliminary in nature.

Table 2 relates to both present coverage and universal coverage. At the present time, somewhat less than 60 percent of the aged are receiving old-age and survivors insurance benefits or earnings (including wives of earners). This proportion will gradually rise to about 85-90 percent in the next 25 years under present old-age and survivors insurance coverage and to 90-95 percent under universal coverage. After that time, there will be a further slow increase to an ultimate figure of close to 100 percent for universal coverage and close to 95 percent for present coverage. At the present time, almost 75 percent of the men are receiving benefits or earnings while for women, the corresponding figure is only about 45 percent. However, by 1980, the ratio for women will be quite close to that for men. This difference in the proportions for men and women is, of course, largely explained by the continued presence of a large number of widows whose husbands died without being insured under the old-age and survivors insurance program.

Table 3 shows the progress of the trust fund under the present coverage, using $2\frac{1}{4}$ percent and $2\frac{3}{4}$ percent of interest. Under the low-cost estimate, the fund builds up steadily, reaching in the year 2000 about \$130 billion for the $2\frac{1}{4}$ percent interest assumption and \$160 billion for $2\frac{3}{4}$ percent and continues to grow thereafter. For the year 2000, benefits and contributions are roughly equal and although benefits increase more rapidly than contributions thereafter, interest on the fund would more than take care of this difference.

Under the high-cost estimate, the trust fund builds up to a maximum of about \$40 billion in 1975–80 for $2\frac{1}{4}$ percent interest and \$47 billion in 1980 for $2\frac{3}{4}$ percent interest and thereafter declines, being exhausted about 20 years later. Under this estimate, contributions generally exceed benefit payments plus administrative expenses until about 1975, although for 1958 and 1959 there is a slight excess of benefits over contributions (these are the last two years that the 4 percent combined contribution rate is in effect) and the same situation also holds true for 1963 and 1964 (the last two years on the 5 percent combined rate).

Under the intermediate-cost estimate, at $2\frac{1}{4}$ percent interest the trust fund builds up to a maximum of about \$65 billion in 1985 and declines slowly thereafter to about \$55 billion in the year 2000. At $2\frac{3}{4}$ percent interest, the corresponding figures are a peak of about \$80 billion in 1990, and \$77 billion in 2000. Carrying the cost estimates out beyond the year 2000, the trust fund continues to decrease until it is exhausted many years later.

Table 4 shows the progress of the trust fund under universal coverage using $2\frac{1}{4}$ percent and $2\frac{3}{4}$ percent interest. Since the cost of the program relative to pay roll is lower than for present coverage and since the dollar amounts involved are larger because of more persons being covered, the resulting trust fund figures are higher, and in any cases where the trust fund reaches a maximum and declines, this point is at a higher amount and is further off in the future than the corresponding figures in Table 3. Under the low-cost estimate, the fund builds up steadily reaching about \$190 billion in 2000 at $2\frac{1}{4}$ percent interest and \$225 billion at $2\frac{3}{4}$ percent interest, and continues to grow thereafter. For the year 2000, contributions are roughly 5 percent higher than benefit payments. Although thereafter benefits increase more rapidly than contributions and after about 20 years become larger, interest on the fund more than takes care of this difference.

Under the high-cost estimate, the fund builds up to a maximum of about \$65 billion in 1980 at $2\frac{1}{4}$ percent interest and to about \$75 billion in 1980–85 at $2\frac{3}{4}$ percent interest and thereafter declines, being exhausted shortly after 2000. Contributions generally exceed benefit payments plus administrative expenses until about 1975.

Under the intermediate-cost estimate, the fund builds up steadily over the next 50 years reaching about \$105 billion in 2000 at $2\frac{1}{4}$ percent interest and about \$135 billion at $2\frac{3}{4}$ percent interest. Thereafter the fund grows more slowly, and for $2\frac{1}{4}$ percent interest eventually reaches a maximum and then declines.

TABLE 1—Comparison of Cost of OASI System for Present Coverage and Universal Coverage

Calendar Year	Benefit Payments (millions)			Benefits as Percent of Payroll		
	Present Coverage	Universal Coverage	Increase in Cost	Present Coverage	Universal Coverage	Increase in Cost
LOW-COST ESTIMATE						
1960.....	\$5,267	\$5,873	\$606	Percent 3.76	Percent 3.34	Percent -0.42
1970.....	7,723	9,059	1,336	4.85	4.55	-0.30
1980.....	10,321	12,385	2,064	5.86	5.64	-0.22
2030.....	13,455	16,029	2,574	6.29	6.01	-0.28
2050.....	21,951	25,887	3,936	6.88	6.52	-0.36
Level-Premium ^a						
at 2½% interest.....				5.69	5.40	-0.29
at 2¾% interest.....				5.42	5.14	-0.28
HIGH-COST ESTIMATE						
1960.....	\$6,166	\$6,814	\$648	4.44	3.91	-0.53
1970.....	8,913	10,631	1,718	5.66	5.40	-0.26
1980.....	11,909	14,277	2,368	6.95	6.68	-0.27
2000.....	16,169	18,739	2,570	8.42	7.81	-0.61
2050.....	22,654	25,658	3,004	10.93	9.90	-1.03
Level-Premium ^a						
at 2½% interest.....				7.63	7.03	-0.60
at 2¾% interest.....				7.12	6.58	-0.54
INTERMEDIATE-COST ESTIMATE ^b						
1960.....	\$5,715	\$6,344	\$629	4.10	3.63	-0.47
1970.....	8,318	9,845	1,527	5.26	4.97	-0.29
1980.....	11,116	13,331	2,215	6.40	6.16	-0.24
2000.....	14,812	17,382	2,570	7.30	6.86	-0.44
2050.....	22,302	25,773	3,471	8.48	7.85	-0.63
Level-Premium ^a						
at 2½% interest.....				6.58	6.15	-0.43
at 2¾% interest.....				6.22	5.82	-0.40

^a Level contribution rate (based on interest rate shown) for benefit payments after 1952, taking into account the accumulated funds at the end of 1952 and future administrative expenses, and assuming that after the year 2050 benefit payments and taxable payroll are level (actually the relationship between benefits and payroll is virtually constant after about 2020).

^b Based on average of the dollar costs under the low-cost and high-cost estimates.

Note: The figures in this table are based on the cost estimate involving high-employment assumptions. See text for explanation of meaning of these figures in regard to financial interchange provisions with railroad retirement system.

TABLE 2—Aged persons receiving OASI benefits or supported by earnings compared with total aged population, present coverage and universal coverage (in millions of persons)

Calendar Year	Total Popula- tion Age 65 and Over	Receiving OASI Benefits or Supported by Earnings *			
		Number		Percent	
		Present Coverage	Universal Coverage	Present Coverage	Universal Coverage
LOW-COST ESTIMATE, TOTAL PERSONS					
1953.....	13.3	7.6	(*)	57	(*)
1955.....	13.9	8.6	(*)	62	(*)
1960.....	15.4	10.7	11.1	69	72
1970.....	18.4	14.4	15.1	78	82
1980.....	22.0	18.7	20.1	85	91
HIGH-COST ESTIMATE, TOTAL PERSONS					
1953.....	13.3	7.6	(*)	57	(*)
1955.....	13.9	9.3	(*)	67	(*)
1960.....	15.5	11.7	12.0	75	77
1970.....	18.7	15.6	16.3	83	87
1980.....	22.8	20.7	21.6	91	95
LOW-COST ESTIMATE, MEN					
1953.....	6.2	4.5	(*)	73	(*)
1955.....	6.5	4.8	(*)	74	(*)
1960.....	7.0	5.5	5.5	79	79
1970.....	8.1	6.7	6.9	83	85
1980.....	9.4	8.4	8.9	89	95
HIGH-COST ESTIMATE, MEN					
1953.....	6.2	4.5	(*)	73	(*)
1955.....	6.5	5.2	(*)	80	(*)
1960.....	7.0	6.0	6.1	86	87
1970.....	8.3	7.2	7.5	87	90
1980.....	9.9	9.4	9.7	95	98
LOW-COST ESTIMATE, WOMEN					
1953.....	7.1	3.1	(*)	44	(*)
1955.....	7.4	3.8	(*)	51	(*)
1960.....	8.4	5.2	5.6	62	67
1970.....	10.3	7.7	8.2	75	80
1980.....	12.6	10.3	11.2	82	89
HIGH-COST ESTIMATE, WOMEN					
1953.....	7.1	3.1	(*)	44	(*)
1955.....	7.4	4.1	(*)	55	(*)
1960.....	8.4	5.7	5.9	68	70
1970.....	10.4	8.4	8.8	81	85
1980.....	12.9	11.3	11.9	88	92

*Not available.

* As used here, "earnings" includes earnings from noncovered employment.

Note: The figures in this table are based on the cost estimate involving high-employment assumptions. See text for explanation of meaning of these figures in regard to financial interchange provisions with railroad retirement system.

TABLE 3—Progress of OASI Trust Fund for Present Coverage (in millions)

Calendar Year	Contribu- tions *	Benefit Payments	Adminis- trative Expenses	Interest Rate at 2¼%		Interest Rate at 2½%	
				Interest on Fund ^b	Fund at End of Year	Interest on Fund ^b	Fund at End of Year
ACTUAL DATA •							
1950-----	\$2,671	\$961	\$61	\$257	\$13,721	\$257	\$13,721
1951-----	3,367	1,885	81	417	15,540	417	15,540
1952-----	3,819	2,194	88	365	17,442	365	17,442
LOW-COST ESTIMATE							
1960-----	\$6,646	\$5,267	\$101	\$657	\$30,482	\$827	\$31,538
1970-----	9,985	7,723	125	1,186	54,982	1,541	58,856
1980-----	11,176	10,321	151	1,868	85,263	2,507	94,016
1990-----	12,224	12,584	175	2,345	106,282	3,303	123,135
2000-----	13,591	13,465	191	2,830	128,585	4,208	157,197
HIGH-COST ESTIMATE							
1960-----	\$6,578	\$6,166	\$134	\$540	\$24,673	\$682	\$25,638
1970-----	9,878	8,913	170	741	34,084	978	36,940
1980-----	10,874	11,909	208	915	40,941	1,271	46,875
1990-----	11,435	14,725	246	557	23,547	938	33,284
2000-----	12,191	16,169	288	(^d)	(^d)	(^d)	(^d)
INTERMEDIATE-COST ESTIMATE •							
1960-----	\$6,612	\$5,716	\$118	\$598	\$27,578	\$754	\$28,588
1970-----	9,932	8,318	148	964	44,533	1,260	47,798
1980-----	11,025	11,116	180	1,392	63,102	1,889	70,446
1990-----	11,830	13,656	210	1,451	84,914	2,120	78,210
2000-----	12,891	14,812	230	1,265	56,412	2,097	77,274

^a Combined employer, employee, and self-employed contributions. The combined employer-employee rate is 3 percent for 1950-53, 4 percent for 1954-59, 5 percent for 1960-64, 6 percent for 1965-69, and 6½ percent for 1970 and after. The self-employed pay ½ of these rates.

^b Actual interest receipts used for 1950-52. For future years, interest is figured at rate shown on average balance in fund. Actual 1951 figure is inflated because it includes a considerable amount of the interest which accrued in the second half of 1950 and also virtually all of the 1951 interest.

^c Based on Daily Statement of the U. S. Treasury. For 1950, benefit payments were those of 1939 Act for first 9 months and those of 1950 Act for last 3 months, and contribution income was that of previous law for entire year. For 1952, benefit payments were those of 1950 law for first 9 months and those of 1952 law for last 3 months.

^d Fund exhausted in 1997.

^e Based on average of the dollar costs under the low-cost and high-cost estimates.

Note: The figures in this table are based on the cost estimate involving high-employment assumptions. See text for explanation of meaning of these figures in regard to financial interchange provisions with railroad retirement system.

TABLE 4—Progress of OASI Trust Fund for Universal Coverage (in millions)

Calendar Year	Contribu- tions *	Benefit Payments	Adminis- trative Expenses	Interest Rate at 2½%		Interest Rate at 2¼%	
				Interest on Fund	Fund at End of Year	Interest on Fund	Fund at End of Year
LOW-COST ESTIMATE							
1960-----	\$8,133	\$5,873	\$118	\$800	\$37,420	\$1,005	\$38,617
1970-----	12,275	9,059	147	1,592	73,885	2,058	78,440
1980-----	13,727	12,385	177	2,554	116,656	3,409	127,967
1990-----	14,970	15,015	203	3,295	149,636	4,605	171,920
2000-----	16,680	16,029	221	4,109	186,960	6,030	225,502
HIGH-COST ESTIMATE							
1960-----	\$8,064	\$6,814	\$154	\$691	\$31,946	\$870	\$33,063
1970-----	12,147	10,631	198	1,097	50,513	1,434	54,225
1980-----	13,367	14,277	238	1,442	64,977	1,974	73,175
1990-----	14,030	17,273	271	1,226	53,952	1,871	68,167
2000-----	15,018	18,739	291	574	24,101	1,259	45,024
INTERMEDIATE-COST ESTIMATE ^b							
1960-----	\$8,098	\$6,344	\$136	\$746	\$34,683	\$938	\$35,840
1970-----	12,211	9,845	172	1,344	62,199	1,746	66,332
1980-----	13,547	13,331	208	1,998	90,816	2,692	100,571
1990-----	14,500	16,142	237	2,260	101,794	3,238	120,044
2000-----	15,849	17,382	256	2,342	105,530	3,644	135,263

* Combined employer, employee, and self-employed contributions. The combined employer-employee rate is 3 percent for 1950-53, 4 percent for 1954-59, 5 percent for 1960-64, 6 percent for 1965-69, and 6½ percent for 1970 and after. The self-employed pay ¾ of these rates.

^b Based on average of the dollar costs under the low-cost and high-cost estimates.

Note: The figures in this table are based on the cost estimate involving high-employment assumptions. See text for explanation of meaning of these figures in regard to financial interchange provisions with railroad retirement system.

DEFINITE PLAN FOR MAKING OUR SOCIAL-SECURITY
PROGRAMS MORE EFFECTIVE

M E S S A G E

FROM

THE PRESIDENT OF THE UNITED STATES

RECOMMENDING

A DEFINITE PLAN FOR MAKING OUR SOCIAL-SECURITY PROGRAMS
MORE EFFECTIVE

AUGUST 1, 1953.—Referred to the Committee on Ways and Means and ordered
to be printed

To the Congress of the United States:

In my message to the Congress on the state of the Union, I pointed out that there is urgent need for making our social-security programs more effective.

I stated that the provisions of the old-age and survivors' insurance law should cover millions of our citizens who thus far have been excluded from participation in the social-security program.

Retirement systems, by which individuals contribute to their own security according to their own respective abilities, have become an essential part of our economic and social life. These systems are but a reflection of the American heritage of sturdy self-reliance which has made our country strong and kept it free; the self-reliance without which we would have had no Pilgrim Fathers, no hardship-defying pioneers, and no eagerness today to push to ever-widening horizons in every aspect of our national life.

The social-security program furnishes, on a national scale, the opportunity for our citizens, through that same self-reliance, to build the foundation for their security. We are resolved to extend that opportunity to millions of our citizens who heretofore have been unable to avail themselves of it.

2 MAKING OUR SOCIAL-SECURITY PROGRAMS MORE EFFECTIVE

The Department of Health, Education, and Welfare, with the counsel and assistance of 12 outstanding consultants, has been carefully studying the difficult technical and administrative aspects of this effort.

The Secretary of that Department has now recommended the specific additional groups which, in the judgment of the Department and its consultants, should be covered under this program. The Secretary has also recommended the means by which these additional groups can be brought into the system most equitably, with full consideration for the new groups as well as those who have heretofore contributed to the insurance system. The Secretary's recommendations would effectively carry out the objectives that I expressed in my message to the Congress on the state of the Union and I am pleased to transmit them to the Congress for its consideration.

Under the attached plan, approximately 10½ million individuals would be offered social-security protection for the first time. About 6½ million of these would be brought into the system; the remaining 4 million would be eligible for coverage under voluntary group arrangements. New groups to be covered would include self-employed farmers; many more farm workers and domestic workers than are now covered; doctors, dentists, lawyers, architects, accountants, and other professional people; members of many State and local retirement systems on a voluntary group basis; clergymen on a voluntary group basis and several other smaller groups.

As the Committee on Ways and Means of the House of Representatives proceeds with its studies to improve the Social Security Act, I strongly commend to it this plan for the extension of coverage to most of the major groups not now covered by any social insurance or public retirement system. This is a specific plan for a specific purpose—the extension of coverage. Other important improvements in the Social Security Act are now under study and will be the subject of further recommendations.

There are two points about these proposals which I cannot stress too strongly. One is my belief that they would add immeasurably to the peace of mind and security of the individual citizens who would be covered for the first time under this plan; the second is my belief that they would add greatly to the national sense of domestic security. The systematic practice of setting aside funds during the productive years to build the assurance of basic retirement benefits when the productive years are over—or to one's survivors in the event of death—is important to the strength of our traditions and our economy. We must not only preserve this systematic practice, but extend it at every desirable opportunity. We now have both such an opportunity and a definite plan. I commend it to the Congress for its consideration.

DWIGHT D. EISENHOWER.

THE WHITE HOUSE, August 1, 1953.

JULY 24, 1953.

The PRESIDENT,

The White House, Washington 25, D. C.

DEAR MR. PRESIDENT: In your state of the Union message of February 2, 1953, you stated:

There is urgent need for greater effectiveness in our programs, both public and private, offering safeguards against the privations that too often come with unemployment, old age, illness, and accident. The provisions of the old-age and survivors' insurance law should promptly be extended to cover millions of citizens who have been left out of the social-security system.

To aid in the development of sound recommendations, I named 12 recognized experts in social security to advise upon the extension of old-age and survivors' insurance. The group included individuals with backgrounds in business, labor, agriculture, private pension plans, and social work, as well as other highly qualified students of social security. A list is attached of the membership of the consultant group.

The consultants made a thorough study of various alternatives for extending old-age and survivors' insurance coverage to all fields, large and small, to which coverage does not now apply. The only fields they did not deal with are those of Federal Government and railroad employment, both of which are under study by other official groups. Federal Government retirement and survivorship problems are being studied by the Committee on Retirement Policy for Federal Personnel authorized by Public Law 555, 82d Congress, and consisting of the Secretary of the Treasury, the Secretary of Defense, the Chairman of the Board of Governors of the Federal Reserve System, the Director of the Bureau of the Budget, and the Chairman of the Civil Service Commission, with a Chairman (Mr. H. Eliot Kaplan, former deputy comptroller of the State of New York under Governor Dewey), appointed by President Truman. All members except the Chairman are now members of this Administration. This committee is due to report on June 30, 1954. Railroad retirement and survivorship problems have been under study by the Joint Congressional Committee on Railroad Retirement, which has completed its work and its report has just been issued.

Our consultants met regularly over a period of 2½ months, with full-day meetings each week for most of that time, and studied a great volume of data and analyses between their meetings. The consultants considered the benefits which will accrue from coverage extension to the groups which are to be covered, the benefits which will accrue to the public, and, in the case of each group, the technical feasibility of coverage.

The consultants submitted a report to me on June 24, 1953, recommending coverage to nearly 10½ million more persons. About 6.5 million more persons would be covered on a mandatory basis and about 4 million more—State and local government employees and clergymen—would have the way opened for social-security coverage under voluntary-group arrangements. In addition, coverage would be continued temporarily—pending the development of a permanent plan—for about 3.5 million members of the Armed Forces. The following groups would be covered:

1. Somewhat over 3 million self-employed farmers with net incomes of \$400 or more in a year, with a simplified method of

reporting income for social-security purposes for the operators of the smaller farms.

2. About 2.7 million farmworkers and 200,000 domestic workers who do not meet the present-time tests for coverage but who are paid \$50 or more in a calendar quarter by a single employer. Domestics, who do not work at least 2 days per week for 1 employer, are not now covered but would be under the proposed bill. Farmworkers are now similarly excluded unless they work very regularly for one employer. Under our new plan, most of these farm laborers would be included in the system.

3. About half a million self-employed professional persons with net incomes of \$400 or more in a year. This includes doctors, dentists, lawyers, engineers, architects, accountants, and funeral directors.

4. Almost 4 million members of State and local government retirement systems (other than policemen and firemen, most of whom are covered by adequate State or local systems) under voluntary agreements between the States and the Federal Government if the members of the system vote in favor of coverage by a two-thirds majority. (While constitutional barriers preclude the Federal Government from imposing an old-age and survivors insurance employer tax upon State and local governments, coverage has been made available to certain employees of State and local governments through Federal-State agreements.)

5. About 200,000 ministers on a basis similar to that on which lay employees of religious and other nonprofit organizations are now covered. (Lay employees are now covered if the employing organization and two-thirds of the employees elect coverage. Of those employed at the time of the election only those who vote for coverage are included but all new employees must be covered.) Whoever is the legal employer of the ministers is authorized to hold an election among the ministers to determine their wishes as to whether they shall be covered. This system has already worked well in respect to lay employees.

6. About 30,000 employees engaged in fishing and similar activities who are not now covered, American seamen employed on foreign vessels by American employers, and certain home-workers.

7. Approximately 3.5 million members of the Armed Forces on a temporary basis. The proposal would continue for a year and a half—through June 30, 1955—the present provisions giving noncontributory wage credits of \$160 a month to members of the Armed Forces. The proposed expiration date of the non-contributory credits would coincide with the expiration of the Universal Military Training and Service Act. This is a stop-gap continuation of a temporary provision of law which was never satisfactory from the standpoint of the old-age and survivors insurance system because it provides benefits to a group for which no contributions are made either by the employer or the employee. The only reason the continuation is recommended is to allow the Committee on Retirement Policy for Federal Personnel (previously referred to, and due to report on or before June 30, 1954) time to recommend a permanent solution

of the problem of retirement and survivorship protection for members of the Armed Forces. The Congress is now considering a separate stopgap bill for members of the Armed Forces and may enact it in advance of a general measure for the extension of coverage.

The consultants have recommended a provision which makes possible the payment of full-rate benefits to newly covered persons within 2 to 3 years for those who are or will then be old enough for retirement. Other newly covered workers could become eligible for full-rate retirement benefits as they reach 65. Eighteen months after the effective date of the measure, survivors of the newly covered earners could, upon the death of the wage earner, become eligible for survivor benefits, just as is the case under current law.

In an attempt to provide coverage to the newly covered groups and at the same time avoid the criticism which arose in 1951 from putting the newly covered groups on an equal footing with those who had been contributing to the system for years, a formula has been developed which is intended to meet the problem. Our proposal permits workers eligible for retirement to drop off their 3 lowest years of earnings in computing their average wages for benefit purposes. Since, under present law, benefit payments for virtually all retired workers are based on average monthly wages from January 1951 to the time of retirement, dropping out the 3 lowest years of earnings will mean that workers newly covered in 1954 will drop out 1951, 1952, and 1953, since they had no recorded earnings during that period. Other workers who have been in the system for some time may drop out any 3 years—past or future—when their earnings may be low or nonexistent for any reason. This will, in many cases, raise the average monthly earnings on which their benefits are based. Depending on when the plan becomes effective, it may be necessary to make an adjustment in this formula so as to drop off the 4 rather than the 3 lowest years.

The consultants did not give consideration to the coverage of Federal civilian employees since this matter is being studied by the Committee on Retirement Policy for Federal Employees. However, representatives of this committee and other interested Federal agencies have been consulted and, as a result, we have concluded that it would be desirable at this time to extend coverage to certain temporary postal employees, civilian employees of Coast Guard "post exchanges," and certain employees of Federal home-loan banks. With these additions, the recommendations of this Department are in full accord with those of the consultants, enumerated above.

All departments and agencies of the Government which are concerned with the extension of the old-age and survivors insurance system have reviewed our proposals to extend the system to those additional groups. There is general agreement within these departments and agencies concerning the desirability of and basis for extending coverage to the groups described above. The Treasury Department and the Bureau of the Budget have been consulted as to appropriate ways to administer the proposals in an effective and economical manner. Simplified methods of reporting, particularly in respect to small farmers, have been developed.

These proposals would permit an additional 10 million people to begin making contributions to a social-insurance program which, in

the American tradition, is designed to provide retirement benefits related, in substantial measure, to the previous earnings and contributions of the individuals who retire—benefits paid as a matter of right without a needs test. Extension of coverage to 10 million more people would be an important long-run step in reducing the need for public-assistance payments out of the general funds of the Treasury. In every respect, I believe, this broader participation in the system will be in the public interest. These proposals, if enacted by the Congress, should effectively carry out the objective of broadening the coverage of the old-age and survivors insurance system which you have repeatedly set forth.

These recommendations are limited to the subject of extending the coverage of the insurance system. Other important phases of the insurance program—some of them very complex—are under careful study. They will be the subject of future recommendations.

Respectfully yours,

OVETA CULP HOBBY, *Secretary.*







[COMMITTEE PRINT]

INCLUSION OF INCOME DERIVED FROM
TIPS AND GRATUITIES FOR PURPOSES
OF COVERAGE UNDER THE OLD-AGE,
SURVIVORS, AND DISABILITY
INSURANCE PROGRAMS

A REPORT BY THE DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE ON A STUDY CALLED
FOR BY THE COMMITTEE ON WAYS AND MEANS
OF THE HOUSE OF REPRESENTATIVES IN HOUSE
REPORT NO. 2288, 85TH CONGRESS, 2D SESSION

SUBMITTED TO THE
COMMITTEE ON WAYS AND MEANS
BY THE
DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE



UNITED STATES

WASHINGTON : 1960

COMMITTEE ON WAYS AND MEANS

WILBUR D. MILLS, Arkansas, *Chairman*

AIME J. FORAND, Rhode Island

CECIL R. KING, California

THOMAS J. O'BRIEN, Illinois

HALE BOGGS, Louisiana

EUGENE J. KEOGH, New York

BURR P. HARRISON, Virginia

FRANK M. KARSTEN, Missouri

A. S. HERLONG, Jr., Florida

FRANK IKARD, Texas

THADDEUS M. MACHROWICZ, Michigan

JAMES B. FRAZIER, Jr., Tennessee

WILLIAM J. GREEN, Jr., Pennsylvania

JOHN C. WATTS, Kentucky

LEE METCALF, Montana

NOAH M. MASON, Illinois

JOHN W. BYRNES, Wisconsin

HOWARD H. BAKER, Tennessee

THOMAS B. CURTIS, Missouri

VICTOR A. KNOX, Michigan

JAMES B. UTT, California

JACKSON E. BETTS, Ohio

BRUCE ALGER, Texas

ALBERT H. BOSCH, New York

JOHN A. LAFORE, Jr., ¹ Pennsylvania

WALTER M. MUMMA, ² Pennsylvania

LEO H. IRWIN, *Chief Counsel*

JOHN M. MARTIN, Jr., *Assistant Chief Counsel*

THOMAS A. MARTIN, *Minority Counsel*

GERARD M. BRANNON, *Professional Staff*

RAYMOND F. CONKLING, *Professional Staff*

¹ Elected Jan. 18, 1960. Resigned Aug. 30, 1960.

² Elected Aug. 30, 1960.

INCLUSION OF INCOME DERIVED FROM TIPS AND GRATUITIES FOR PURPOSES OF COVERAGE UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAMS

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, April 5, 1960.

HON. WILBUR D. MILLS,
*Chairman, Committee on Ways and Means,
House of Representatives, Washington, D.C.*

DEAR MR. MILLS: As requested by your committee in its report on H.R. 13549, the Social Security Amendments of 1958, the Department of Health, Education, and Welfare and the Department of the Treasury have studied the question of covering tips under the old-age, survivors, and disability insurance program. Described below is a plan for covering tips as wages under old-age, survivors, and disability insurance which the two departments recommend for enactment. The recommended plan also provides for applying the income tax withholding procedure to tips.

The Departments are agreed that the plan adopted should meet two major objectives: (1) Since tips received by an employee from a customer of his employer grow out of an employment relationship, they should be treated, to the extent possible, like wages paid directly by the employer, with the employer paying his share of the social security tax; (2) the actual amount of tips received by the employee should be covered to the extent possible, but provision should be made for the use of an alternative computation when the actual amount of tips is not known to the employer. The recommended plan realizes both of these objectives.

The staff of the Department of Health, Education, and Welfare have explored with representatives of employer and employee groups the problems that would be involved in covering tips as wages. It has not been possible, however, to develop a plan that would be fully satisfactory to these groups.

Except for tips received infrequently or in amounts that are nominal in the aggregate, the plan would apply to all tips received from customers of the employer. The employee would be required by statute to report such tips to his employer in writing. In the absence of such report the employer would be required to report and remit taxes on an amount determined by the following guide: If the employee's wages were less than 60 cents per hour the employer would report enough tips to bring the total of wages and tips up to \$1 an hour; if the regular wages were 60 cents an hour or more the employer would report 40 cents per hour in tips. As under present law, the employer would be required to pay both the employer and employee social security taxes, and would have the right to collect the employee tax from the employee.

In the absence of a report the employer's liability for the social security taxes would be limited to taxes on the amount of tips computed in accordance with the statutory guide. If the employee reported less than his actual tips, but the amount specified in the guide or more, the employer would not incur liability with respect to the amount underreported. If the employee reported less than his actual tips, and the actual tips did not exceed the guide amount, the employer would be liable for taxes on the actual tips.

If the employee reported less tips than he had actually received, and the actual tips were more than the guide amount, the employee would remain liable for the additional employee tax due with respect to actual tips in excess of the guide amount. The employee would be liable also for another amount equal to such additional tax, or, in effect, an aggregate equal to both the employer tax and employee tax on such unreported tips above the guide amount. This requirement, which in effect charges the employee for the employer's share of the tax, gives recognition to the fact that the employee's failure to report actual tips to the employer prevented the employer from paying the correct amount.

For the purposes of income tax withholding, the statute would be amended to include tips as wages, and to provide that in the absence of a report by the employee to the employer tips would be computed under the same guide as is prescribed for social security tax purposes. The employer's obligation to withhold income tax from such tips would be limited, however, to any funds of the employee in his possession, such as unpaid remuneration. This limitation on the employer's obligation would in no way affect the employee's liability for income tax on the amount of tips actually received.

We shall be glad to furnish any further information your committee may need for the consideration of the question of covering tips and to assist in preparing any legislative language that may be required.

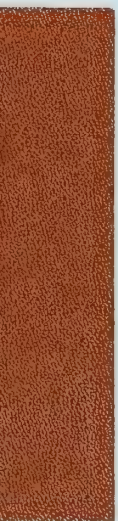
The Bureau of the Budget advises that it perceives no objection to the submission of this proposal to your committee.

Sincerely yours,

ARTHUR S. FLEMMING, *Secretary.*

○





89th Congress }
1st Session }

COMMITTEE PRINT

SOCIAL SECURITY AND FEDERAL EMPLOYMENT

A REPORT REQUESTED BY
THE COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

SUBMITTED BY THE
UNITED STATES CIVIL SERVICE COMMISSION
AND THE
SOCIAL SECURITY ADMINISTRATION
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE



MARCH 13, 1965

NOTE: This report is being printed for informational purposes only

Printed for the use of the Committee on Ways and Means

WASHINGTON : 1965

COMMITTEE ON WAYS AND MEANS

WILBUR D. MILLS, Arkansas, *Chairman*

CECIL R. KING, California	JOHN W. BYRNES, Wisconsin
HALE BOGGS, Louisiana	THOMAS B. CURTIS, Missouri
EUGENE J. KEOGH, New York	JAMES B. UTT, California
FRANK M. KARSTEN, Missouri	JACKSON E. BETTS, Ohio
A. S. HERLONG, JR., Florida	HERMAN T. SCHNEEBELI, Pennsylvania
JOHN C. WATTS, Kentucky	HAROLD R. COLLIER, Illinois
AL ULLMAN, Oregon	JOEL T. BROYHILL, Virginia
JAMES A. BURKE, Massachusetts	JAMES F. BATTIN, Montana
CLARK W. THOMPSON, Texas	
MARTHA W. GRIFFITHS, Michigan	
W. PAT JENNINGS, Virginia	
GEORGE M. RHODES, Pennsylvania	
DAN ROSTENKOWSKI, Illinois	
PHIL M. LANDRUM, Georgia	
CHARLES A. VANIK, Ohio	
RICHARD H. FULTON, Tennessee	

LEO H. IRWIN, *Chief Counsel*

JOHN M. MARTIN, JR., *Assistant Chief Counsel*

WILLIAM H. QUEALY, *Minority Counsel*

LETTER OF SUBMITTAL

MARCH 13, 1965.

HON. WILBUR D. MILLS,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Enclosed is the report of the Civil Service Commission and the Social Security Administration giving you the results of a study by these agencies of ways of filling gaps in retirement, survivors and disability protection of workers which arise because civilian employment for the Federal Government is not covered under social security. This report was requested by the Committee on Ways and Means in its report (H. Rept. 1799, 86th Cong.) on the Social Security Amendments of 1960 (H.R. 12580). The relevant part of the committee report follows:

Employees of the Federal Government constitute one of the last major groups of workers who do not have coverage available to them under the old-age, survivors, and disability insurance system. Your committee is aware that in certain cases this creates inequitable treatment and gaps in protection. It is also aware, however, that extension of coverage to this group will involve substantial policy questions and commitments by both the workers and the employer—the Federal Government. Your committee, therefore, urges that the appropriate Federal agencies concerned accelerate their efforts in finding a workable and sound solution to this problem and report it to the Congress at the earliest opportunity.

Various possible solutions to the problems your committee referred to in its report were analyzed with respect to their effect upon the overall benefit protection of persons with Federal employment—both long-term career civil servants and those who spend only a part of their working lifetimes in civil service work. Our analysis was concentrated on the six basic types of approaches which have been considered over the years for providing social security protection for Federal workers:

(1) Extend social security coverage to Federal civilian employment, and make no adjustments in the civil service retirement system.

(2) Permit present and future Federal civilian employees to elect social security coverage on an individual voluntary basis while continuing to be covered under the present provisions of the civil service retirement system. (Similar to approach No. 1, except that employee participation would be voluntary.)

(3) Extend social security coverage to Federal civilian employment, with adjustments in the benefit level and contribution rates of the civil service retirement system which would take into account the contributions and benefits of social security.

(4) Extend social security coverage to Federal civilian employment, with adjustments in the civil service retirement system (as under approach No. 3), but permit present employees to elect

to come under the new combined coverage or to continue under the present provisions of the civil service retirement system and not come under social security. Employees hired in the future would be compulsorily covered under social security and would be subject to the adjusted civil service retirement system provisions.

(5) Provide social security protection by means of transfers of credits from the civil service retirement system to social security in all cases where workers with Federal employment are not eligible for protection under the civil service retirement system upon their reaching retirement age, severe long-term disablement, or death.

(6) Provide social security protection by means of transfers of credits (as under approach No. 5) but only in the case of workers who separate, die, or become disabled with less than 5 years of Federal employment.

On the basis of our exploration of the advantages and disadvantages of these six approaches, a transfer-of-credit plan which follows approach No. 5 appears to offer "a workable and sound solution" to the problem of filling gaps in the protection of workers who have Federal employment. It does not, on the other hand, have certain advantages that some coverage-coordination plans have. This approach would require no changes in the provisions of the civil service retirement system, other than provisions for financing the plan, and would avoid difficulties which so far have prevented legislative action in this area. Thus, by providing benefit protection under social security in all situations where, under present law, no benefits would be payable under the civil service retirement system, the plan would close major gaps in the protection of workers who have Federal employment and would, moreover, be a relatively inexpensive approach.

Under this transfer-of-credit plan, credit for the Federal employment of workers who die, become disabled, or leave work covered under the civil service retirement system with less than 5 years of work under that system would be transferred to social security. (In this type of situation, the separated employees have no disability or survivorship protection under the civil service system.) Also, the credits of workers who leave Federal employment with more than 5 years of work covered under the civil service retirement system, and who lose their benefit protection under that system, would be transferred to social security. Appropriate financial adjustments between the two systems would be made to take account of the transfers of credit.

The Advisory Council on Social Security recently completed its study of the social security program and reported its findings and recommendations. In respect to social security protection for Federal employees, the Council recommended a transfer-of-credit plan that is similar to the one described above.

We recognize that this approach has shortcomings. For example, approach No. 5 would provide social security survivor and disability protection for workers with less than 5 years of Federal service which would be better than the survivor and disability protection afforded many of the workers with more than 5 years of service under the civil service retirement system. To correct this situation would require changes in the survivor and disability protection now provided by the civil service retirement system, perhaps by adding to a transfer-of-

credit plan a provision guaranteeing benefit amounts that would be no less than those that would be paid under social security. Also, a transfer-of-credit plan would have no effect in situations where workers qualify for benefits under both social security and the civil service retirement system in total amounts which may be considered high in relation to the worker's lifetime earnings and contributions.

The administration is at present making a comprehensive study of retirement provisions for Federal personnel. This study will include further consideration of the role of social security in the protection afforded Federal personnel through social security and the civil service and other staff retirement programs. The Cabinet committee established to make this study has been asked to report to the President by December 1, 1965.

Sincerely,

JOHN W. MACY, JR.,
Chairman, U.S. Civil Service Commission.
ROBERT M. BALL,
Commissioner of Social Security.

as well. In private industry some 35,000 pension plans are built on social security. The retirement system for railroad workers is coordinated with social security. Over 4 million of the 6¾ million employees of State and local governments are now covered under social security, and about three-fourths of those under social security are also covered by public staff-retirement systems. Social security coverage has also been extended to the 2.7 million members of the Federal uniformed services, who are also covered under staff-retirement plans, to about 200,000 Federal civilian employees (mainly temporary employees) not under a Federal staff-retirement system, and to 18,000 employees of the Tennessee Valley Authority, of whom about 11,000 are under a staff-retirement system.

Almost all of the 2.3 million Federal civilian employees who are excluded from social security are subject to the civil service retirement system,³ the principal staff-retirement system for civilian employees of the Federal Government. In accord with its purpose of encouraging qualified employees to make a career in Federal service, the system provides excellent protection for employees who have completed long periods of service. With significant exceptions in the area of disability benefits (and, to a lesser extent, survivor benefits) benefits under the civil service retirement system are closely related to both the employee's length of service and the amount of his pay.⁴ The system is currently financed by employee contributions of 6½ percent of pay and by a matching contribution from the Government. Over the long run, however, the level cost of the system on a "normal cost plus interest" basis is estimated to be 22.33 percent of payroll (of which 6½ percent is contributed by employees and the remaining 15.83 percent is the cost to the Government). The normal cost (13.49 percent of payroll) is defined as the average percentage of the salaries of new employees that is required to be paid into the civil service retirement and disability fund from the time they enter service until they leave service in order to accumulate sufficient amounts to pay their benefits. When the fund was originally established, employees were given credit for their prior service during which "normal cost" had not been paid, thus creating a "deficiency" liability, which has grown through the years for various reasons, such as liberalization of benefits, including benefits based on prior service. Annual interest on the deficiency (at 3½ percent) amounts to 8.84 percent of payroll, so that the two items (normal cost and interest) add to 22.33 percent of payroll required for level financing of the system.

Survivors and disability protection

During the first 5 years of Federal employment, workers and their families have no survivors or disability protection under the civil service retirement system and any social security protection based

³ As indicated in footnote 1, a relatively small number of Federal employees are covered under one of several other staff retirement systems, such as the Foreign Service retirement system.

⁴ To illustrate, the retirement benefit of a worker with 5 years of service is 7½ percent of pay (averaged over the 5 years) while that of a worker with 30 years of service is about 56 percent of average pay (based on the 5 years of highest earnings). Benefits to workers who become totally disabled after at least 5 years of service and who entered Federal service prior to age 38 are not less than 40 percent of average pay during the highest 5 years. The widow of an employee who dies after 5 years of service gets about 4 percent of his average pay (based on his 5 years of highest earnings); the widow of a 10-year employee, about 9 percent; and the widow of a 30-year employee, about 31 percent. However, flat amounts are provided for surviving children—generally \$50 a month, but less if there are more than 3 children and more if no widow or widower survives.

on previous work is likely to be lost or impaired.⁵ Survivors of an employee who dies before completing 5 years of service get a refund of the worker's contributions to the civil service retirement system.⁶ In some instances—those in which the deceased worker is still insured for social security survivor protection on the basis of having worked under social security before he entered Federal service—the survivors can get social security benefits; but the social security benefit amounts will not reflect his recent earnings and may be quite low because of the period of time that the worker spent in noncovered employment. Similarly, the worker who becomes totally disabled during his first 5 years of Federal service has no protection under the civil service retirement system. Federal civilian workers who become disabled during this period, and their families, are even less likely than in the death cases to qualify for social security disability protection because to be insured for this protection the disabled worker must have had recent, as well as substantial, work covered by social security.⁷ At a given time, about 14 percent of employees under the civil service retirement system have less than 5 years of service.⁸

Even though they have worked 5 or more years in Federal employment covered by the civil service retirement system, all workers who leave that employment before retirement cease to have survivor and disability protection based on their years of Federal service. A very high proportion of these workers—and there are many thousands each year—not only lose their survivor and disability protection under the civil service retirement system but also are without social security protection (either because they never worked under social security or because they have not worked under social security for some time) and will continue to be without such protection for some time to come.⁹

Retirement protection

Of those workers who leave Federal service before retirement, only a small minority will receive a retirement benefit based on their Federal service.

A 1961 study of people who left work covered by the civil service retirement system (other than persons who retired or died) showed that less than 8 percent gained and retained any protection under the civil service retirement system as a result of their Federal service. About

⁵ To be eligible for disability protection under social security a worker must be in covered employment for at least 5 years in the 10-year period before he becomes totally disabled, and must also be fully insured—that is, he must have been in covered work for a period equal to about one-fourth of the time after 1950 (or age 21, if later) and up to the time he becomes totally disabled. The minimum requirement for fully insured status is about 1½-years of covered work; the eventual minimum will be 10 years of coverage. To be eligible for survivors' protection, a worker must be either fully or "currently" insured. He becomes currently insured by working in covered work for approximately 1½-years out of the 3-year period immediately preceding his death. If the worker is currently, but not fully, insured, child's benefits, mother's benefits, and a lump-sum death payment can be paid. Benefit amounts are based on average earnings credited under social security. The years a worker spends in Federal service not covered by social security tend to diminish his average earnings for the purposes of the social security benefit computation, and therefore the benefit amount to which he or his family may become entitled.

⁶ Upon separation, including separation because of death, from work covered by the civil service retirement system after less than 5 years of service, the employee's contributions to the system (6½-percent of pay) are refunded with interest. Almost all employees also are covered under Federal employees' group life insurance, to which they contribute about two-thirds of 1 percent of pay. This plan pays approximately 1 year's salary to survivors, with double indemnity in case of accidental death, and includes benefits for accidental dismemberment. This protection stops when an employee leaves Federal service (except upon career or disability retirement or while receiving compensation for service-connected disability, when life insurance continues free), subject to a 31-day extension of life insurance during which he may convert to an individual life insurance policy at standard rates without a medical examination. Service-connected disability or death is compensable under the Federal Employees' Compensation Act.

⁷ See footnote 5.

⁸ See app. B, table 2.

⁹ See footnote 5.

two-thirds of those who left did so before they had worked 5 years and thus did not meet the minimum requirements for protection under civil service retirement. Of those employees who separated from Federal employment after 5 years or more of Federal work, but before retirement, 77 percent withdrew their contributions within 6 months after they separated¹⁰ and thereby lost all rights to benefits under civil service retirement. (See table 3 in app. B.) These rights may be regained only if the worker is reemployed in work covered by the system.

According to the 1961 study, almost 60 percent of the people who separated from Federal service and withdrew their contributions to the civil service retirement system were men. While the men who end up getting no retirement benefits under the civil service retirement system on the basis of their Federal service may qualify for social security benefits, these benefits will usually be lower because they will not reflect their years of Federal service. The same is, of course, true of the social security benefits that women earn in their own right. Married women are in a somewhat different position than single women, since a married woman who withdraws her contributions will have some retirement protection through the social security wife's benefit based on her husband's work.¹¹

As can be seen from the above analysis, whether the benefit protection obtained by the millions of employees whose work lifetimes are divided between jobs under social security and work covered by the civil service retirement system is adequate may turn on the element of chance. In many cases, the worker does not become eligible for benefits under one of the systems, and therefore the years of service and the earnings he had under that system do not count in figuring the benefits he and his survivors will get. Some workers may end up without eligibility for benefits under either system; for example, workers may surrender their protection under the civil service retirement system by withdrawing their contributions and not work long enough in other employment to qualify for social security benefits.

Those who qualify for both social security and civil service retirement benefits

On the other hand, some persons may qualify for benefits under both systems in a total amount which seems unreasonable in relation to their total earnings and contributions.

Social security benefits, being based on social insurance principles, are heavily weighted to provide benefits to low-paid earners that are relatively high in relation to earnings and contributions. Under present law, the formula underlying the benefit tables provides 58.85 percent of the first \$110 of creditable monthly earnings and 21.4

¹⁰ Many people who do not initially withdraw their contributions may later decide to do so. Statistics of the U.S. Civil Service Commission indicate that in recent years an average of only 4,000 people per year come on the civil service retirement rolls for deferred annuities. The number of persons separating from Federal employment (most of whom were not under the Civil Service Retirement Act and had less than 5 years of service) has been no lower than 340,000 in any year since the beginning of World War II, and in several years during the 1940's was well in excess of one million.

¹¹ The social security wife's benefit equals one-half of her husband's benefit. A woman entitled both as a worker and a wife receives an amount equal to the larger of the two benefits. Social security coverage may be quite valuable to a married woman. Her entitlement to benefits on her own account is not affected by various contingencies that apply to wife's or widows' benefits. For example, a woman who had earlier anticipated receiving a wife's benefit may not be eligible because she has in the meantime become divorced or because her husband has failed to qualify for social security benefits. Also, if the woman is older than her husband, her own work may provide her with social security benefits prior to the time her husband qualified for benefits. Another consideration is that a woman may not receive a wife's benefit when she reaches retirement age (but would be eligible to receive her own benefit as a retired worker) if her husband continues to work after he reaches retirement age. Moreover, women may through their own work acquire valuable disability and survivors protection which they cannot acquire on the basis of a husband's work.

percent of the next \$290 of earnings. In addition, social security pays a minimum monthly benefit of \$40 a month to an insured retired worker who comes on the rolls at or after age 65, and a minimum of \$60 for such an insured worker with one dependent (a child, or a wife aged 65 or over), with corresponding minimum benefits for surviving dependents. As a result of this weighted benefit formula, persons who generally work in employment not covered by social security but have enough social security coverage to qualify get an advantage in the benefit-contributions relationship that is intended for low-paid workers. For example, even highly paid Federal career employees with substantial civil service retirement benefits can, through regular or part-time employment, acquire the required 40 quarters of coverage under social security (fewer quarters are now required for older workers) and with very low creditable earnings (average monthly earnings under social security of \$67 or less) can qualify for the minimum benefits.

This problem is not unique to Federal employment, of course, but exists with respect to all noncovered employment.

PREVIOUS EFFORTS TO FIND A SOLUTION AND THE EFFECT OF CHANGES
IN THE CIVIL SERVICE RETIREMENT SYSTEM ON PRESENT CON-
SIDERATION

The problems arising because of the exclusion from social security of work covered by the civil service retirement system have long been recognized. The 1938 Advisory Council on Social Security recommended that studies be made of the problems involved in extending social security coverage to Government employees. The 1948 Advisory Council on Social Security recommended to the Senate Committee on Finance that as a temporary measure the wage credits of Federal employees who die or leave Federal employment with less than 5 years' service should be transferred to social security, and that a permanent plan should be developed for covering Federal civilian employees under social security. The Committee on Retirement Policy for Federal Personnel (the Kaplan Committee) in 1954 recommended that civilian employees of the Federal Government be covered under social security, with appropriate adjustments to be made in the civil service retirement system.¹² In 1956, the Eisenhower administration recommended that Congress enact proposed legislation based on the Kaplan Committee study.

The Social Security Administration and the Civil Service Commission have also given much attention over the years to alternative plans for providing social security protection for Federal employees. The issues in developing a satisfactory proposal are somewhat different now than they were at the time of the Kaplan Committee study because of the improvements that have been made in the civil service retirement system during the last decade.

The more important changes that have been made in the provisions of the civil service retirement system (by legislation enacted in 1956 and 1962) are: (a) increase in the basic annuity formula from $1\frac{1}{2}$ percent of high-5-year average pay for each year of service to $1\frac{1}{2}$ percent for each of the first 5 years of service, $1\frac{3}{4}$ percent for each of the next 5 years, and 2 percent for each year of service after the 10th; (b) provision of a guarantee (generally speaking) of 40 percent of

¹² App. E describes this recommendation in some detail.

high-5-year average pay for employees under age 60 qualifying for disability annuities; (c) improvement of survivor annuities; (d) provision for automatic cost-of-living increases for annuitants; and (e) increase in the employee contribution rate to $6\frac{1}{2}$ percent of pay, compared with 6 percent in 1954. In 1954, the cost of the civil service retirement system was estimated at 15.70 percent of payroll—11.15 percent was the normal cost and 4.55 percent was a deficiency cost. At present, the cost estimate is 22.33 percent—13.49 percent normal cost and 8.84 percent deficiency cost (described on pp. 10-16).

As one result of these changes, the retirement benefit amounts of career employees have been substantially improved. Thus, for a worker retiring after 35 years of service the retirement-benefit formula in effect in 1954 generally provided a benefit amounting to $52\frac{1}{2}$ percent of his high-5-year average pay. The present formula provides $66\frac{1}{4}$ percent of high-5-year average pay for the retired worker with 35 years of service. The provisions for automatic increases in benefit amounts to take account of cost-of-living increases also represent a significant improvement in the protection provided by the civil service retirement system.

These changes have also increased the cost of the system to a point where the cost of further improvements in the level of protection provided long-term career employees raises questions as to what the public policy should be as to what proportion of the compensation of Federal employees is to be in the form of deferred compensation. There is also a question as to whether employees' contributions should be increased beyond the $6\frac{1}{2}$ percent of pay they now contribute to the civil service system, considering, among other things, that most employees also make payments under the Federal employees' health insurance program and the Federal employees' life insurance program.

APPROACHES CONSIDERED IN THE PRESENT STUDY

In carrying out the request of the Committee on Ways and Means, we explored various general approaches to the problem of gaps in the protection of people who have Federal employment, and a number of tentative plans based on these general approaches. This section of the report describes the general approaches considered, and the principal considerations underlying each.

Approach No. 1.—Extend social security coverage to Federal employment covered by the civil service retirement system without making any changes in the provisions of the retirement system. (This approach is sometimes referred to as the "fully additive" approach.) Employees would continue to pay contributions to the civil service retirement system at the present rate ($6\frac{1}{2}$ percent of total pay) and would also pay social security employee contributions;¹³

¹³ Social security contribution rates for employees and employers provided under present law and under H.R. 1 (the proposed Hospital Insurance, Social Security, and Public Assistance Amendments of 1965) are as follows:

Years	Employee-employer (each)	
	Present law	H. R. 1
1966-67.....	4.125	4.25
1968-70.....	4.625	5.0
1971 and after.....	4.625	5.2

Present law covers the first \$4,800 of annual earnings; H. R. 1 would cover the first \$5,600.

there would be no reduction in the Government's cost in respect to the civil service retirement system, and the Government would, in addition, pay social security employer contributions. Employees would receive all benefits payable under the present civil service retirement system as well as those payable under social security. (For illustrative monthly benefits payable under a fully additive plan, see app. C.)

Considerations

(a) This approach would go beyond filling gaps in the retirement, survivor, and disability protection of those who shift between Federal employment and other work and would provide benefit amounts which for many career employees would be very high when compared with prior earnings levels. Since Federal workers could get full benefits under both the civil service retirement system and the social security system, it would not be rare, under this approach, for Federal workers to retire with benefits that equal or exceed their salaries.

Example A.—An individual works in Federal employment from age 25 to 65, with final salary of \$500 a month. Under the fully additive approach, and assuming the social security benefit provisions of present law, a retired worker and his wife, after she reaches 65, would get total benefits of \$557¹⁴ a month in civil service and social security benefits, or more than 110 percent of salary; the single worker would get \$508 a month.

Example B.—After 5 years in a job in private industry an individual works in Federal employment for 5 years averaging \$420 a month and then becomes totally disabled. He has a wife and one young child. Under the fully additive approach, the family would get monthly benefits of \$442 a month or slightly more than his salary.

(b) The fully additive approach would be the most costly for employees and the Government. Under the social security contribution rates scheduled under present law, employees would soon be required to pay an additional 4.625 percent of the first \$4,800¹⁵ of their annual pay, and these contributions would have to be matched by the Government. Even assuming that neither the civil service retirement contribution rate nor the ultimate social security contribution rate increases in the future, employees would be paying in excess of 11 percent of pay up to \$4,800 a year toward protection under civil service retirement and social security. For the Government, the additional cost of providing protection under the fully additive approach would amount to more than 3 percent of payroll, or about \$500 million a year.

(c) The fully additive approach has been used in extending social security coverage to some Government employees.¹⁶ Some State and local government retirement systems have added social security coverage without adjusting the provisions of the staff-retirement systems. In most such cases, however, the staff-retirement system

¹⁴ Based on the assumption that the worker accepted a reduced CSR annuity in order to provide CSR survivor protection for his wife. If such provision were not made, the total benefits would amount to \$572 a month for the worker and his wife.

¹⁵ 5.2 percent of the first \$5,600 under H. R. 1.

¹⁶ When social security coverage was extended to the Federal uniformed services (1956), various existing survivor provisions were adjusted to take the social security coverage into account but no reduction was provided in the retirement benefits under the existing staff-retirement systems. One consideration was that the formula for computing the retirement benefits—both the social security benefits and the staff-retirement benefits—of members of the uniformed services is applicable to service base pay and thus does not reflect the value of noncash items which represent a substantial part of the total pay of most servicemen. In most cases a serviceman's total pay, including allowances or the value of quarters and food, exceeds his base pay by 30 percent or more.

benefits payable were low, and when social security benefits were added the resulting total was generally well below the level which would be reached by adding social security benefits to those of the Federal civil service retirement system.¹⁷

(d) A consideration which would be applicable to any plan involving compulsory social security coverage of Federal employees is that some employees, because of their personal situation, believe they would not receive enough additional financial advantage from the social security coverage of their Federal work to make it personally advantageous to pay the scheduled contribution rates.

(i) In the case of some persons who expect to stay in Federal employment until they retire but who expect to qualify also for social security benefits on the basis of non-Federal work, the social security coverage of their Federal work may not be particularly advantageous. Persons with Federal employment who qualify for social security benefits based on only a small part of their lifetime earnings have low average monthly earnings for social security purposes, and will gain the advantage of the weighted benefit formula which is intended to provide a relatively high benefit return for people who actually have low average earnings over a lifetime. As a result of this and other social security provisions, the increases in social security benefits from the coverage of Federal work for people who will qualify for social security benefits based on non-Federal work would not be as large relative to the social security taxes they would pay on the basis of their earnings from Federal employment as in the case of the benefits which would be payable without Federal coverage; however, for most such employees the additional social security benefit amount would still represent a good buy for the employee.

(ii) In many cases, women workers who expect to qualify for a wife's social security benefit (or widow's benefit, in the event their husband's death precedes theirs) believe social security coverage of their own work would not be of enough advantage to make it personally advantageous to pay the social security contributions.¹⁸

(iii) Some older employees who have had no previous social security coverage may expect that they will not be covered under social security long enough to become insured before they retire.

Approach No. 2.—Provide social security coverage for Federal employees on the basis of individual choice, without any changes in

¹⁷ An exception is the New York State Employees' Retirement System. Employees covered by this system and by social security can qualify for benefits which represent a relatively high proportion of pay. The State system offers the employee a choice between an "age 55" plan, which is designed to give him "half-pay" retirement benefits (based on the average of his salary in his last 5 years of service) after 30 years of service at minimum age 55, and an "age 60" plan, which is designed to give him "half-pay" retirement benefits after 35 years of service at minimum age 60. (The "half-pay" is made up of two elements—a pension financed by the State, and an annuity financed partly by the State and in many cases wholly by the State.) As compared to the "half-pay" benefits the State system is intended to produce, the Federal civil service retirement system pays retirement annuities of 56¼ percent of the high-5-year average salary after 30 years of service, and 66¼ percent after 35 years of service. Social security coverage was extended to employees covered by the New York State Employees' Retirement System on Sept. 30, 1957, under a provision which permitted all current employees to choose whether to come under social security while continuing to be covered under the State system; employees hired after Sept. 30, 1957, are covered under social security (and the State system) on a compulsory basis.

¹⁸ As noted earlier, a social security wife's benefit is equal to one-half of the husband's benefit, and, in general, a woman entitled to wife's benefits and benefits because of her own work gets an amount equal to the larger of the two. A widow at age 62 receives a benefit equal to 82½ percent of the benefit her husband would have received; a younger widow (with a child entitled to benefits in her care) get three-fourths of the husband's benefit. Some women may feel that the increased amounts they would get because of coverage of their own work would not be enough larger than a wife's or widow's benefits to warrant paying the social security contributions. However, protection based on their own work may be quite valuable for them. (See footnote 11.)

their protection under the civil service retirement system. This approach is the same as approach No. 1 except that employee participation would be on an individual voluntary basis. Employees electing social security coverage would pay social security employee contributions (in addition to their contributions to the civil service retirement system); the Government, as employer, would pay social security employer contributions in respect to those employees who elected coverage.¹⁹

Considerations

(a) The considerations discussed under approach No. 1 relative to high benefits and costs are also applicable to this approach, except that total employer costs would not be as large as under approach No. 1 because not all employees would elect social security coverage. However, the high employer cost for some employees would be even less justifiable than under approach No. 1 because the additional expenditures by the Government as employer, under this approach, would go mostly toward raising the benefits (sometimes to the point of paying retirement benefits in excess of earnings) of the better paid career workers (who would be in a better position to assume the cost of social security employee contributions). If Government costs are to be increased it would not seem desirable to have the increased expenditures go to provide higher benefits for those who can afford, and take the initiative to elect, social security coverage. Moreover, because some employees would not elect coverage, the aim of filling gaps in protection for those who move in and out of Federal work would not be fully achieved.

(b) Proposals to provide individual voluntary coverage under social security have been considered from time to time by the Committee on Ways and Means and the Committee on Finance and it was always concluded that social security coverage on an individual voluntary basis is undesirable. The same conclusion was reached by the 1965 Advisory Council on Social Security.²⁰ In its report the Council states: "It is essential that the coverage of the program remain on a compulsory basis. If coverage were voluntary, the program could not effectively carry out its purpose of providing basic protection for all. The improvident would not be inclined to elect coverage. Many workers who have great need for protection and limited opportunity to acquire it through private means—low income workers, workers with large families and workers in poor health—would choose not to pay social security contributions because of pressing day-to-

¹⁹ Under a somewhat similar plan which is favored by some Federal employees, social security coverage would be made available to Federal employees on the basis of individual choice, in addition to their coverage under the civil service retirement system, and those electing coverage would be covered under the social security provisions designed for the coverage of self-employed persons. (The social security contribution rate for self-employed persons is 1½ times the employee rate, and equals three-fourths the combined employee-employer contribution rate.) Apart from the objections to providing social security coverage on a continuing individual voluntary basis, this plan would have other objectionable features. Such a plan would (a) except the Government, as employer, from its obligation, imposed by law on other employers, to bear part of the cost of social insurance for its employees, (b) impose on the employees a higher cost burden than that borne by other employees, and (c) result in an unwarranted and unsound reduction in the contribution rate received by the social security system for Federal employees below the rate applying to wage or salary employment generally.

²⁰ The Advisory Council on Social Security, composed of distinguished representatives of business, labor, self-employed people, and the general public, made a comprehensive review of the social security program and on Jan. 1, 1965, issued its report, "The Status of the Social Security Program and Recommendations for Its Improvement." As required by law, the Advisory Council was appointed by the Secretary of Health, Education, and Welfare in 1963 to study all aspects of the social security program, including the financing of the program, extensions of coverage, and the adequacy of benefits, and to make a report of its findings and recommendations. The Council's statement concerning individual voluntary coverage appears on pp. 74-75 of its report.

day needs. Moreover, permitting individual voluntary coverage would increase program costs and give those allowed such coverage an unfair advantage over workers who are covered on a compulsory basis."

(c) Employees and groups of employees other than civilian employees of the Federal Government have expressed interest in being permitted to choose on an individual basis whether or not to be covered under social security. If the Federal Government were to permit continuing individual voluntary coverage for its own employees, other workers would have a strong case for requesting the same treatment. Thus, approach No. 2 could lead to individual voluntary coverage in additional employment areas, compounding the problems which result from the voluntary coverage of Federal employees.

Approach No. 3.—Extend social security coverage to Federal employment covered by the civil service retirement system, with some reduction in benefits and contributions under the civil service system to take account of the contributions and benefits of the general social security system (sometimes described as a "coverage-coordination" approach).²¹ To be acceptable, a plan which follows this approach would have to be designed so that the protection provided under the civil service retirement system, plus the protection provided under social security on the basis of covered work, would always be at least equal to and usually somewhat superior to that provided under the present civil service retirement system alone.

Considerations

(a) This approach more than any other has the potential for assuring a reasonable relationship between benefits and lifetime contributions and service in the case of people who shift between Federal employment and other work. Since the benefit level of the civil service retirement system would be modified so that the level of benefits provided under it would be based on the assumption that social security benefits would also be payable, the combined benefits (and also the combined contributions) would be at a planned and systematic level.

(b) A coverage-coordination plan, with employees qualifying for independently computed benefits²² under social security and civil service retirement based on the same period of Federal service, seems certain to require further increases in certain benefits, particularly retirement benefits for many long-term career employees, which have already been considerably increased in recent years (discussed on pp. 5 and 6). Such increases would result because of the need to avoid deliberalizing present benefits for some employees. To illustrate one of the various problems in designing a plan of this kind, if an unmarried worker's civil service retirement annuity is reduced under a given formula so that the total of his reduced annuity and his social

²¹ This approach is the one that has been most commonly used to provide protection under social security and a staff-retirement system in private industry, State and local government, and other areas of employment—that is, the most common pattern is that the protection under the staff-retirement system is designed to be a supplement to the basic protection that the employees have under social security. It is the approach proposed by the Kaplan Committee in 1954. (See app. E.)

²² An offset method of coordination, under which civil service retirement benefits would be reduced by a specified percentage of whatever social security benefits are earned in Federal employment, would be somewhat more efficient than independently computed benefits from the standpoint of providing consistent treatment in all cases. However, it would seem to link the civil service retirement system very closely with social security—a point on which some Federal employee organizations have expressed the greatest concern. The use of the offset method in private industry is, in general, confined to systems to which the employee does not contribute.

security benefit is slightly in excess of the civil service retirement annuity provided under present law, the same formula will, in effect, give a married worker with a somewhat similar record of earnings and service a substantial increase because of the social security wife's benefit that will be payable to his spouse. For example, under the coordination plan in appendix D, the same benefit-computation formula which would provide an increase of less than 5 percent in retirement benefits to a \$6,000-a-year single worker with 32 years of Federal service would provide an increase of about 22 percent in the retirement benefits (including social security wife's benefits) of a \$6,000-a-year married worker with 40 years of Federal service.

Thus if the adjusted civil service retirement benefits are set high enough to assure that the total of the civil service and social security benefits will be at least as high as present civil service benefits in all instances, large increases, which seem difficult to justify, would result in the combined benefits which would be payable in some cases. Though the increase in the cost would not be as large as under fully additive coverage, this approach, as a practical matter, would involve increasing costs beyond what is necessary to merely fill gaps in existing protection. For example, the total additional cost of the plan illustrated in appendix D is estimated at 2.63 percent of civil service payroll and that plan may be very close to the lowest cost coverage plan that would not deliberalize present protection and would be reasonably simple and understandable.

(c) This approach in particular has been strongly opposed by organizations of Federal employees, who apparently feel that, once social security coverage is provided and benefits under the civil service retirement system are reduced, the role of the civil service retirement system in providing protection for Federal employees would become much less important. Presumably, they believe that it would be more difficult or even impossible to obtain congressional action to improve the special staff retirement features of the civil service retirement system for long-term career employees once Federal employees are provided with the protection of the generally applicable social security system, and that further improvements in their retirement, survivors, and disability protection would tend to be limited to those made in the social security system.²³

Also, aside from the possible long-range effect of the proposal upon civil service retirement system benefits in general, many present Federal employees with long service apparently believe that even initially the legislation modifying the civil service retirement system would be such that, looked at from a personal point of view, their overall protection would not be increased enough to make such coverage desirable for them. In addition to situations discussed earlier where social security coverage may not seem very advantageous to some individuals—for example, married women and Federal employees who have social security coverage through other work—annuitants under the civil service retirement system can earn any amount in non-Federal work without such work affecting their annuities, whereas social security beneficiaries may have their benefits, or part of them, withheld under a retirement test which applies to

²³ However, in private industry and other areas of employment many good staff-retirement systems are maintained as supplements to social security coverage and staff-retirement provisions have been improved to further benefit long-service employees.

all earnings.²⁴ Therefore, long-term career Federal employees who expect to work in non-Federal employment after reaching the age at which they could receive their social security benefits (age 62 for reduced benefits, age 65 for unreduced benefits) anticipate that they would lose by getting only the reduced benefit under the civil service retirement system, and no social security benefit, for a period of time after they leave Federal employment.

Approach No. 4.—Extend social security coverage to Federal employment, with modifications in the provisions of the civil service retirement system, but permit current employees to elect to come under the combined coverage or to continue under the present provisions of the civil service retirement system and not come under social security. Employees hired in the future would be compulsorily covered under social security, and would also be covered under the provisions of the civil service retirement system as modified to take into account social security protection. This approach is the same as approach No. 3 except for the option afforded current employees. One of the various ways in which this approach could be implemented is illustrated by the detailed plan in appendix D.

Considerations

(a) This approach is designed to meet objections, discussed earlier, of many present employees who do not want their Federal work covered under social security, such as workers already insured under social security whose benefits would not be greatly increased by additional coverage, married women who expect to get social security wife's benefits, and workers near retirement age who might not be covered long enough to become insured, and others who do not see enough personal advantage in social security coverage to want to pay the contributions.

(b) Provisions under which current employees are given a choice as to social security coverage and future employees are compulsorily covered have been applied quite successfully to employees of State and local governments in a number of States. Such provisions are not subject to the objections to permitting voluntary social security coverage on a continuing basis, since the adverse effects on the social security program would be temporary and therefore relatively minor.

(c) This approach, just as in the case of approach No. 3, would require nonessential increases in certain benefits, particularly benefits for many long-service career employees, in order to avoid deliberalizing benefits for some employees. As in the case of approach No. 3, costs would be increased beyond what is necessary to fill gaps in protection.

(d) This approach, as in the case of approach No. 3, has been opposed by organizations of Federal employees, since there would be a reduction in benefits provided by the civil service retirement system. (These objections are discussed on p. 15.) In addition, under approach No. 4 there would be a group of employees who would not elect social security coverage, but would continue under the present provisions of the civil service retirement system. Since the number of workers so covered would gradually decline with the passage of time, there may be even more concern than in the case of approach

²⁴ Under the social security retirement test, old-age and survivors insurance benefits are paid to people under age 72 only if they are substantially retired from work. Generally speaking, a beneficiary who earns less than \$1,200 in a year receives all his social security benefits; a beneficiary who earns more than \$1,200 in a year has \$1 in benefits withheld for each \$2 in earnings between \$1,200 and \$1,700, and for each \$1 for earnings above \$1,700.

No. 3 that it would be difficult to obtain further improvements in the civil service retirement system.

Approach No. 5.—Provide for transfers of credit for Federal employment to social security under a plan which would be broad enough to provide social security protection for all workers with Federal employment who are not eligible for protection under the civil service retirement system when they reach retirement age, become disabled, or die. This is the approach which was recommended by the 1965 Advisory Council on Social Security. (See app. G.) A transfer-of-credit arrangement is included as part of the present railroad retirement-social security coordination.²⁵

Considerations

(a) This approach would fill major gaps in the present survivor, disability, and retirement protection of those who spend part of their work lifetimes in Federal employment but do not continue to have protection under the civil service retirement system after they leave Federal employment. All such persons who are not protected under the civil service retirement system upon death, disablement, or retirement would have social security protection based on their Federal work (as well as other work).²⁶

(b) This approach would be much less expensive than approaches involving extension of coverage to Federal employment. The additional cost of a minimum-type "coverage-coordination" plan under approaches No. 3 and No. 4 (app. D) is estimated to be 2.63 percent of civil service payroll, and the fully additive approaches identified as approaches No. 1 and No. 2 would be even more expensive. The additional cost of a transfer-of-credit proposal consistent with approach No. 5, however, is estimated to be only about 1 percent of civil service payroll. This is true because the transfer-of-credit plan does not increase benefits of long-term career employees who stay in the Federal service. However, even those employees would have had valuable survivor and disability protection under social security during their early years of service.

(c) This approach would avoid the relatively high combined benefits which would result in some situations from coverage-coordination plans and more frequently from plans which would provide social security coverage without any adjustments in civil service retirement benefits.

(d) A transfer-of-credit plan would require no modification of the provisions of the civil service retirement system, other than to make provision for financing the plan. Thus, a transfer-of-credit plan would not affect the benefits of long-term career employees who stay in the Federal service, and could not reasonably be opposed as interfering

²⁵ The railroad retirement-social security coordination provides for the transfer of credits from the railroad program to social security upon the death, disablement, or retirement of a worker with less than 10 years of railroad work. In survivors cases in which the worker had 10 or more years of railroad employment, records are combined. If the worker had a current connection with the railroad industry at the time of his death, or at the time he becomes entitled to a retirement annuity, social security credits are transferred to the railroad retirement program, and payment is made by that program; if there is no current connection with the railroad industry, railroad credits are transferred to social security, and payment is made by that program. The survivor provisions of the railroad retirement program are modeled after and are almost identical with the survivor benefit provisions of social security, a fact which makes it reasonable to transfer credits in either direction. An across-the-board minimum benefit guarantee based on the social security benefit formula applies to all beneficiaries under the railroad program. Also, railroad benefits are, in effect, reinsured under social security by provisions in the Railroad Retirement Act which provide for cost adjustments between the two programs which place the social security trust funds in the position they would have been in if railroad employment had been covered under social security since 1937.

²⁶ App. F illustrates the improved protection resulting from a transfer-of-credit plan that follows this approach.

with the future development of provisions designed to improve the protection afforded such employees.

(e) Since this approach would not ordinarily have any effect upon the benefit status, under either program, of Federal employees who qualify for benefits under the civil service retirement system, it would not assure that a rational benefit related to the worker's lifetime record would be paid in all instances. This approach would, in fact, provide survivor protection (and in many cases, disability protection) for workers who have not completed 5 years of Federal employment that would be better than the survivor protection the workers would have at the point that they complete 5 years, and for some time thereafter.²⁷

Approach No. 6.—Provide for transfers of credit for Federal employment to social security, but only for employees who separate, die, or become disabled in Federal service with less than 5 years of work under the civil service retirement system.

Considerations

(a) This approach would fall short of the objective of filling the major gaps in the protection of those who move between Federal employment and other work. The major gaps in protection include gaps in retirement, survivors, and disability protection of the large numbers of workers who leave Federal employment after 5 or more years of service. Under this approach, none of these employees would carry social security protection with them when they leave Federal employment for other jobs.

(b) Because this approach would not deal with the problem of employees who are separated after 5 or more years of Federal service, it would involve somewhat less additional cost than approach No. 5.

(c) This approach would be even less effective than approach No. 5 in assuring payment of rational benefits related to a worker's lifetime earnings record in all instances. It would, moreover, give rise to an anomaly not involved in approach No. 5, in that the Federal employees who would not have social security protection upon separation would be those with the largest gaps in their social security coverage.

SUMMARY AND CONCLUSION

In summary, it appears to us that the principal advantages and disadvantages of the various approaches are as follows:

Approach No. 1 (employees covered under social security and the civil service retirement system, with no adjustment in the provisions of that system). Avoiding adjustment in the civil service retirement system provisions would be in accord with the views of employee organizations but the additional cost of this approach would be very high for employees and the Government. This approach would go beyond the objective of filling gaps in protection and would result in large increases in the benefits of many career employees; in some

²⁷ To illustrate, in the case of a young worker who works for 1 year under social security and 4 years under civil service retirement, averaging \$500 a month, and then dies, the widow and 1 child would receive social security survivor benefits of \$191 a month under the transfer-of-credit plan. If, however, the worker dies 1 year later, when he completes 5 years of Federal employment, the widow and child would receive \$71 a month from the civil service retirement system and would not be eligible for social security benefits. Under the railroad retirement-social security coordination (see footnote 25) this type of inequity is avoided through a provision guaranteeing a minimum benefit based on the social security benefit formula. To correct this situation would require changes in the civil service retirement system. (The operation of the railroad retirement-social security minimum provision if it were applied to the civil service retirement system is discussed in app. H.).

instances, retirement benefit amounts would exceed the employee's pay.

Approach No. 2 (same as approach No. 1 except that present and future employees could individually elect whether to come under social security). This approach has been favored by some employee organizations. The additional cost for the Government would not be quite as high as under approach No. 1 since some employees would not elect social security coverage. However, the additional Government cost would go toward providing high benefits for those employees who elected coverage—mainly the better paid employees who could readily afford to pay the social security employee contributions. Individual voluntary coverage under social security has always been considered undesirable because it involves adverse selection, which increases social security costs at the expense of those covered on a compulsory basis, and because some of those who have greatest need for social security protection would not elect coverage. Because some employees would not elect coverage, the objective of filling gaps in protection would not be fully achieved.

Approach No. 3 (employees covered under social security and the civil service retirement system, with adjustments in the retirement-system provisions to take account of social security coverage). A plan carrying out this approach would fill the gaps in protection and could be designed to accomplish this objective at substantially less cost than approaches No. 1 and No. 2. This approach more than others has the potential to assure that the combined benefits (and the combined contributions) of people who shift between work covered by social security and the civil service retirement system would be at a planned and systematic level. This approach would, however, require some increase in cost beyond that necessary to fill the gaps in protection. Past proposals which involved adjustments of provisions of the civil service retirement system to take account of social security coverage have been strongly opposed by organizations of Federal employees.

Approach No. 4 (same as approach No. 3 except that present employees could elect to come under the new combined coverage or to continue under present provisions of the civil service retirement system and not come under social security). The considerations applicable to approach No. 3 are also generally applicable to this approach. The option provided under approach No. 4 would meet objections of some present employees based on individual circumstances, but this approach has also been strongly opposed by organizations of Federal employees because of the changes which would be made in the provisions of the civil service retirement system for the long run.

Approach No. 5 (a transfer-of-credit plan broad enough to provide social security protection for workers with Federal employment who do not qualify for protection under the civil service retirement system). A transfer-of-credit approach would not be as effective as coverage-coordination plans in assuring a planned and systematic level of contributions and benefits for workers who shift between Federal employment and other work. However, approach No. 5 would achieve the objective of filling major gaps in the protection of workers with Federal employment without involving costs, such as would be involved in the coverage plans, for providing nonessential benefit

increases. Since this approach would not change the provisions of the civil service retirement system relative to career employees who stay in the Federal service, it would avoid objections which have been raised by employee organizations against plans which would make such changes.

Approach No. 6 (transfer of credits to social security in cases where employees die, become disabled, or separate before completing 5 years of Federal service). This approach would leave major gaps in protection unfilled, and would be even less effective than approach No. 5 in assuring a planned and systematic level of contributions and benefits for workers who shift between Federal employment and other work. It would, however, involve less additional cost than other approaches.

Conclusion

We have concluded that the transfer-of-credit approach, such as described under approach No. 5, is a workable and sound way of providing social security protection for Federal employees who do not qualify for benefits under the civil service retirement system. The transfer-of-credit plan which would follow approach No. 5 is described in appendix F. The plan would alleviate very serious problems which arise where no protection has been provided under the civil service retirement system. We believe that any arrangement that would fail to provide social security protection in the situations covered by this plan would fall short of being responsive in the minimum acceptable degree to the need of the workers for protection, and to the concern expressed by the Committee on Ways and Means when it requested the agencies to develop a way of dealing with the problem faced by persons with Federal employment. However, even this approach would not fill the gaps in survivorship and disability benefits for workers with 5 to 20 years of service or solve the problem involving workers who qualify for benefits under both social security and the civil service retirement system in total amounts which may be considered high in relation to the worker's lifetime earnings and contributions.

APPENDIXES

- Appendix A. Principal provisions of the Civil Service Retirement Act.
 - Appendix B. Selected data on Federal civilian employment.
 - Appendix C. Illustrative monthly benefits payable under a fully additive plan.
 - Appendix D. A plan for extending social security coverage to Federal civilian employees who are covered by the civil service retirement system, and adjusting provisions of the retirement system to take account of social security coverage.
 - Appendix E. Recommendations of the Kaplan Committee for extension of OASDI coverage to employment covered by the Federal civil service retirement system.
 - Appendix F. A transfer-of-credit plan which follows approach No. 5.
 - Appendix G. Recommendation of the Advisory Council on Social Security concerning Federal employment.
 - Appendix H. Operation of the railroad retirement-social security minimum provision if applied to the civil service retirement system.
-

APPENDIX A

PRINCIPAL PROVISIONS OF THE CIVIL SERVICE RETIREMENT ACT

A. TYPES OF BENEFITS

1. Age and service retirement benefit:
 - (a) Compulsory at or after age 70 with 15 years' service—full annuity terminating at death;
 - (b) Voluntary:
 - (i) At age 62 with 5 years' service—full annuity terminating at death;
 - (ii) At age 60 with 30 years' service—full annuity terminating at death;
 - (iii) At age 55 with 30 years' service—reduced annuity if under age 60, terminating at death;
 - (c) Involuntary (not for cause), at any age with 25 years' service or at age 50 or over with 20 years' service—reduced annuity if under age 60, terminating at death.

Cost-of-living increases first possible on the April 1 occurring 15 months or more after annuity begins.

2. Disability retirement benefit: At any age with 5 years' service, with finding of disability by Civil Service Commission—full annuity (special minimum) terminating at death or with recovery or restoration of earning capacity before age 60.

Cost-of-living increases first possible on the April 1 occurring 15 months or more after annuity begins.

3. Deferred retirement benefit: 5 or more years' service, refund not elected—full annuity at age 62, terminating at death.

Cost-of-living increases first possible on the April 1 occurring 15 months or more after annuity begins.

4. Lump-sum withdrawal: (a) Less than 5 years' service—refund of accumulated contributions; (b) 5 years' service, not eligible for immediate annuity—choice of refund or deferred retirement benefit.

5. Lump-sum benefit (death before retirement): No specified period of service, no survivor with annuity rights—refund of accumulated contributions.

6. Special lump-sum benefit (guaranteeing return of employee contributions): Payable if annuitant dies and no survivor has annuity rights or survivor annuities have terminated—refund of accumulated contributions less all annuity payments.

7. Survivor child benefit (death before retirement):

(a) With surviving parent and 5 years' service—benefit (terminating at death, marriage, or attainment of age 18 unless disabled, but continuing to attainment of age 21 for full-time students in recognized educational institutions) is the smallest of—

- (i) 40 percent of employee's "average salary," divided by number of children,
- (ii) \$1,800 divided by number of children,
- (iii) \$600.

Cost-of-living increases do not apply to the maximum defined in (i). Cost-of-living increases in maximums defined in (ii) and (iii) first possible on April 1, 1964, applying to computation of all future survivor child benefits at death of employee. After death of employee, further cost-of-living increases first possible on the April 1 occurring 15 months or more after annuity begins.

(b) With no surviving parent and 5 years' service—benefit under same conditions as in 7(a), except that benefit is the smallest of:

- (i) 50 percent of employee's "average salary" divided by number of children,
- (ii) \$2,160 divided by number of children,
- (iii) \$720.

Cost-of-living increases under same conditions as in 7(a).

8. Survivor child benefit (death after retirement):

(a) With surviving parent and 5 years' service—benefit (terminating at death, marriage, or attainment of age 18 unless disabled, but continuing to attainment of age 21 for full-time students in recognized educational institutions) is the smallest of—

- (i) 40 percent of employee's "average salary" divided by number of children,
- (ii) \$1,800 divided by number of children,
- (iii) \$600.

Cost-of-living increases in maximum defined in (i) first possible on the April 1 occurring 15 months or more after parent's annuity begins. Cost-of-living increases in maximums defined in (ii) and (iii) first possible April 1, 1964, applying to computation of all future survivor child benefits at death of employee annuitant. After death of employee annuitant, further cost-of-living increases, first possible on the April 1 occurring 15 months or more after child's annuity begins.

(b) With no surviving parent and 5 years' service—benefit under same conditions as in 8(a), except that benefit is the smallest of—

- (i) 50 percent of employee's "average salary" divided by number of children,
- (ii) \$2,160 divided by number of children,
- (iii) \$720.

Cost-of-living increases under same conditions as in 8(a).

9. Survivor spouse benefit (death before retirement), 5 years' service, payable to widow or disabled dependent widower—55 percent of regular service annuity, terminating at death or remarriage of widow or widower, or the widower's becoming capable of self-support.

Cost-of-living increases first possible on the April 1 occurring 15 months or more after annuity begins.

10. Elective survivor benefits (death after retirement):

(a) For married annuitant, payable to designated spouse—55 percent of amount designated by employee, terminating at death or remarriage of spouse;

(b) For unmarried annuitant (election not available for disability retirement), payable to designated person—55 percent of annuity, reduced for the election, terminating at death of beneficiary.

Cost-of-living increases first possible on the April 1 occurring 15 months or more after employee annuity begins. After death of employee annuitant, further increases first possible on the April 1 occurring 15 months or more after survivor annuity begins.

B. COMPUTATION OF BENEFIT AMOUNTS

1. "Average salary": Highest average annual basic salary during any 5 consecutive years.

2. Total service: Number of years plus full months expressed as fraction of year.

3. Basic annuity: The sum of—
 - (a) 1½ percent of "average salary," or 1 percent of "average salary" plus \$25, whichever is greater, times first 5 years of service;
 - (b) 1¼ percent of "average salary," or 1 percent of "average salary" plus \$25, whichever is greater, times second 5 or less years of service;
 - (c) 2 percent of "average salary," or 1 percent of "average salary" plus \$25, whichever is greater, times service in excess of 10 years.
4. Maximum annuity: 80 percent of "average salary" but see item (1) under "Financing."
5. Minimum annuity (disability retirement only): The lesser of (a) 40 percent of "average salary," or (b) basic annuity computed using total actual service plus assumed additional service to age 60.
6. Reduction for retirement under age 60: No reduction for disability retirement. Otherwise, total annuity reduced by one-twelfth of 1 percent for each full month that the retiring employee is under age 60, except that if under age 55, reduction is 5 percent plus one-sixth of 1 percent for each full month that the employee is under age 55.
7. Reduction for unpaid deposits: Retiring employee fails to make full deposit due for noncontributory service; reduction in annuity (on an annual basis) is 10 percent of unpaid amount.
8. Optional reduction for survivor benefits:
 - (a) Married annuitant elects reduction for benefit of 55 percent of designated amount of annuity to wife or husband; reduction is 2½ percent of the first \$3,600 of designated amount plus 10 percent of designated amount in excess of \$3,600. Election automatic (with designation of full amount of annuity) unless employee specifies otherwise.
 - (b) Unmarried annuitant elects reduction for benefit of 55 percent of reduced annuity to designated beneficiary; reduction is 10 percent of annuity plus 5 percent for each full 5 years the designated beneficiary is younger than the annuitant (total reduction not to exceed 40 percent). Option not available for those retiring for disability.

C. FINANCING

1. Employee contributions: 6½ percent of basic salary; after employee has served long enough to earn maximum annuity of 80 percent of "average salary" (generally slightly less than 42 years), all future contributions, plus 3-percent interest, are at retirement applied toward deposits due for refunded or non-contributory service or treated as voluntary contributions, available for purchase of additional annuity or refund.
2. Agency contributions: 6½ percent of basic salary.
3. Congressional appropriation: Civil Service Commission submits annual estimates of additional appropriations required.
4. Retirement fund investments: Principally invested in specially authorized U.S. issues; interest on current investments at a rate equal to the current average market yield on all outstanding U.S. marketable obligations not due or callable until after 4 years from such issuance. Current rate on new investments, 4¼ percent; current overall earning rate about 3¼ percent.

APPENDIX B

SELECTED DATA ON FEDERAL CIVILIAN EMPLOYMENT

TABLE 1.—*Mobility of Federal civilian employees as indicated by net accessions and separations, United States, 1955-64*¹

Fiscal year	Net accessions ²	Net separations ³	Fiscal year	Net accessions ²	Net separations ³
1955	475,000	419,000	1960	451,000	382,000
1956	437,000	372,000	1961	436,000	326,000
1957	458,000	380,000	1962	501,000	355,000
1958	404,000	370,000	1963	427,000	361,000
1959	397,000	340,000	1964	397,000	343,000

¹ Sources: Annual Report of U.S. Civil Service Commission, Federal Employment Statistics Bulletin, Graphic Presentation of Federal Employment, U.S. Civil Service Commission, Washington, D.C.

² Excludes transfers between agencies, and returns to duty from leave without pay and military service.

³ Excludes transfers between agencies, separations to enter military service, extended leaves without pay, and separations due to death, retirement, and disability.

TABLE 2.—*Length of Federal service of Federal employees under the civil service retirement system, June 30, 1963*¹

Length of service	Number of employees	Percent distribution
Total.....	2,300,000	100.0
Under 5 years.....	313,040	13.6
5 to 9 years.....	440,500	19.2
10 to 14 years.....	435,320	18.9
15 to 19 years.....	453,390	19.7
20 to 24 years.....	457,560	19.9
25 to 29 years.....	122,840	5.3
30 years and over.....	77,350	3.4

¹ Source: Federal Employment Statistics Bulletin. U.S. Civil Service Commission, November 1963. Employees have no protection under the civil service retirement system until they have completed 5 years of service.

TABLE 3.—*Withdrawal of contributions to civil service retirement system by employees separating from Federal employment after 5 or more years of service, by age and length of service*¹

Attained age in 1960	Total			Completed years of service ²								
	Number	Withdrawals	Percent	5 to 9			10 to 19			20 and over		
				Number	Withdrawals	Percent	Number	Withdrawals	Percent	Number	Withdrawals	Percent
Total.....	1,402	1,075	77	1,016	822	81	361	244	68	25	9	36
20 to 29.....	160	141	88	158	140	89	2	1	50	-----	-----	-----
30 to 39.....	555	476	86	412	360	87	142	115	81	1	1	100
40 to 49.....	421	306	73	281	213	76	127	87	68	13	6	46
50 to 59.....	233	136	58	143	99	69	80	35	44	10	2	20
Over 59.....	33	16	48	22	10	45	10	6	60	1	0	0

¹ Source: Characteristics of Persons Separating and Withdrawing Contributions From the Federal Civil Service Retirement System. Analytical Note No. 6-61 prepared by Joseph Krislov, Social Security Administration, June 1961. Employees who separate after 5 or more years of service and withdraw their contributions thereby forfeit rights to a deferred annuity at age 62. (Employees who separate after less than 5 years of service are eligible only for a refund of their contributions.)

² Individual's Federal civilian service, unbroken by any refunds, for 1,182 persons, and individual's total Federal civilian service, including years for which refunds were paid, for 220 persons. Data include only withdrawals of contributions taken within 1st 6 months following separation.

APPENDIX C

ILLUSTRATIVE MONTHLY BENEFITS PAYABLE UNDER A FULLY ADDITIVE PLAN

Retirement benefits to retired worker and wife ¹

Monthly pay ²	A. Work history—40 years, all in Federal service		B. Work history—32 years Federal, 8 years non-Federal service		C. Work history—25 years Federal, 15 years non-Federal service		D. Work history—15 years Federal, 25 years non-Federal service	
	Present law	Fully additive	Present law	Fully additive	Present law	Fully additive	Present law	Fully additive
\$333 (\$4,000 per annum):								
CSR.....	\$250	\$250	\$198	\$198	\$152	\$152	\$87	\$87
OASDI:								
Worker.....	0	112	0	112	69	112	88	112
Wife.....	0	56	0	56	35	56	44	56
Total.....	250	418	198	366	250	320	219	255
\$500 (\$6,000 per annum):								
CSR.....	366	366	294	294	225	225	128	128
OASDI:								
Worker.....	0	127	0	127	75	127	97	127
Wife.....	0	64	0	64	38	64	49	64
Total.....	366	557	294	485	338	416	274	319
\$833 (\$10,000 per annum):								
CSR.....	594	594	474	474	369	369	213	213
OASDI:								
Worker.....	0	127	0	127	75	127	97	127
Wife.....	0	64	0	64	38	64	49	64
Total.....	594	785	474	665	482	560	359	404

¹ Assumes employee and wife are both aged 65 when he retires, and that employee elects reduced CSR annuity to provide CSR survivor protection for wife. An employee who does not elect this reduction would of course receive somewhat higher benefits than those indicated above for the retired worker, both under present law and under coordination.

² Average pay during 5 highest earnings years in Federal service. Average earnings under OASDI are assumed to be these amounts or \$400 per month (\$4,800 per annum) whichever is less. All employment occurs after effective date of plan.

SURVIVORS BENEFITS—FULLY ADDITIVE PLAN

Illustrative monthly benefits payable to a widow with two minor children of a worker who dies while in Federal employment, after 10 years of Federal service. His "high-5-year average pay" is \$6,000; his average annual earnings for OASDI purposes is \$4,800.

	System paying benefits	Present law	Fully additive plan
Widow with 2 minor children ¹	CSR.....	\$145	\$145
	OASDI.....	0	254
Total.....		145	399

¹ Child's benefits under OASDI terminate when the child reaches age 18. Benefits to a widow under age 62 terminate when there are no longer any children of the worker under age 18. Child's benefits under CSR terminate generally at age 18, unless the child is a student, in which case benefits continue up to age 21. Widow's benefits under CSR are payable regardless of the age of the widow or whether or not there are still children of the worker under age 21.

Illustrative monthly benefits payable to a widow with no minor children of a worker who dies in Federal employment, after 25 years of Federal service. His "high-5-year average pay" is \$6,000; his average annual earnings for OASDI purposes is \$4,800.

	System paying benefits	Present law	Fully additive plan
Widow over age 62.....	CSR..... OASDI.....	\$127 0	\$127 105
Total.....		127	232

APPENDIX D

A PLAN FOR EXTENDING SOCIAL SECURITY COVERAGE TO FEDERAL CIVILIAN EMPLOYEES WHO ARE COVERED BY THE CIVIL SERVICE RETIREMENT SYSTEM, AND ADJUSTING PROVISIONS OF THE RETIREMENT SYSTEM TO TAKE ACCOUNT OF SOCIAL SECURITY COVERAGE

SUMMARY OF PROVISIONS OF COORDINATION PLAN

Employees who are subject to civil service retirement contributions before January 1, 1966, would have an option to remain under civil service retirement only or to elect coverage under both CSR and OASDI. Employees who become subject to CSR contributions on or after January 1, 1966, would be covered under both OASDI and CSR. When both an OASDI benefit and a CSR annuity are payable, the CSR annuity would be reduced under a formula which takes into account the employee's length of Federal service under the coordination plan; the reduction formula would not provide any reduction for the period during which the employee was covered only by the CSR system, or for any OASDI covered employment for non-Federal service.

Giving a choice of coverage to present employees is comparable to the so-called "divided retirement system" provision which has been used in extending coverage to many State and local government employees who are members of retirement systems. The requirement that all employees hired in the future must be covered under OASDI limits adverse selection to current employees. Giving a choice to current employees seems justified when the choice is between one type of coverage or another, and not between coverage or no coverage.

SPECIFIC PROVISIONS

1. OASDI coverage

(a) Employees subject to CSR contributions on December 31, 1965, would make a one-time irrevocable election to (1) stay under CSR only, or (2) come under the coordination plan with coverage under both CSR and OASDI. In general, present employees would make their elections on a specified election date prior to January 1, 1966; however, special provision would be made to afford newly hired employees a reasonable period of time to consider the plan before making an election.

(b) Six quarters of retroactive OASDI coverage would be extended to all employees who elect to come under the plan and who have been continuously subject to CSR since June 30, 1964. Appropriate FICA tax payments for the retroactive coverage would be made by the employee and by the Government, accomplished through a transfer from the CSR fund. Less than six quarters of retroactive coverage would be extended to employees not in Federal service subject to CSR for the whole retroactive period. A currently insured OASDI status would exist from the effective date of the coordination plan for employees who elect to come under the plan and who receive the full six quarters of retroactive coverage.

(c) New employees (those entering Federal service on or after January 1, 1966) would be covered under OASDI from the beginning date of their employment. Persons employed prior to December 31, 1965, who reenter Federal employment after a break in service that includes that date would be covered under OASDI from the beginning date of their reemployment after December 31, 1965.

(d) The coordination plan would not propose extension of OASDI coverage to Members of Congress and congressional employees.

(e) Categories of Federal civilian employees now excluded from CSR coverage and covered only under OASDI would continue to be covered only under OASDI.

2. *CSR coverage*

(a) Present coverage provisions as they apply to new employees would be retained. Temporary and intermittent employees would continue to be excluded.

(b) Employees subject to CSR contributions on December 31, 1965, could, as indicated in item 1(a), elect to remain under the present provisions of the CSR system, or to be covered under both CSR and OASDI.

3. *Contributions*

(a) *OASDI*.—Social security (FICA) contributions would be at the rates scheduled in the law, on basic salary up to \$4,800. Thus, employees and the employing agency would each contribute $4\frac{1}{8}$ percent for 1966–67, and $4\frac{5}{8}$ percent for 1968 and thereafter. The maximum annual cost would be \$222 for the employee, matched by \$222 for the employer. Retroactive contributions for 6 quarters retroactive coverage would be made on the basis of the $3\frac{5}{8}$ percent rate for 1965 and 1964. The maximum retroactive contributions would be \$261 each for employer and employee.

(b) *CSR*.—An employee who is subject to both CSR and OASDI would contribute to the CSR fund $6\frac{1}{2}$ percent of his basic salary over \$4,800 and a smaller percentage of his basic salary up to \$4,800. Agency “matching” contributions would be made on a similar basis. An employee who is subject only to CSR would continue to contribute $6\frac{1}{2}$ percent of all basic salary, with equivalent agency matching contributions.

4. *Benefits payable*

(a) All OASDI benefits would be payable as under present law, including, where applicable, old-age benefits, wives’ benefits, disability benefits, and survivor benefits for widows, dependent widowers, children, and dependent parents.

(b) *Conditions for reduction of CSR annuity*.—A retirement, disability, or survivor annuity under CSR would be reduced only if: (1) The person receiving the annuity becomes entitled to an OASDI benefit (or would, upon application, become entitled to an OASDI benefit that is not actuarially reduced) based on the employee’s OASDI earnings record for Federal service under the coordinated plan; and (2) the employee’s Federal service covered under OASDI would be sufficient to give him OASDI insured status, based on the provisions of the Social Security Act in effect on January 1, 1966. (Subsequent liberalizations of OASDI insured status would not be considered in determining whether the annuity is to be reduced.)

(c) *Amount of reduction in age and service retirement annuity*.—Several proposed reduction formulas were considered. Each of them would provide an annual reduction of the employee’s annuity based on the number of years of dual coverage, up to a specified maximum number of such years. The reduction under the formula considered most feasible is as follows:

One percent of “high-5” average (or, if less, \$48) multiplied by years of Federal service after December 31, 1965,¹ not in excess of 30.

The formula would apply directly in the case of persons receiving unreduced OASI benefits. If a person is entitled to actuarially reduced OASI benefits the reduction in his CSR annuity would be somewhat smaller. In such a case, the amount by which the CSR annuity is reduced would be adjusted downward by the same percentage as the OASI benefit is reduced. The present maximum benefit provision of CSR (80 percent of high-5 year average salary) would be applied before an annuity is reduced to take OASDI benefits into account.

(d) *Reduction of disability annuity*.—Provided the disabled employee is eligible for social security disability benefits, a disability annuity that is computed without resorting to the CSR minimum guarantee² would be reduced in the same manner as age and service retirement annuities. The reduction of a disability annuity computed under the minimum guarantee provisions would be based not on the employee’s actual service but on the total service he would have needed to “earn” the disability minimum annuity if the normal CSR retirement formula had applied instead. Any years of coverage under CSR only would be deducted from this total. The result would be entered as “Federal service after December 31, 1965” in the formula for computing the CSR annuity reduction.

¹ Plus a maximum of $1\frac{1}{2}$ years of retroactive coverage.

² The minimum disability annuity provided under CSR is the lesser of (a) 40 percent of the “high-5” average salary, or (b) an annuity computed under the basic annuity formula using the actual service plus assumed additional service to age 60. However, an employee is not eligible for disability protection under CSR until he has completed 5 years of civilian service.

If the disabled employee is not eligible for social security disability benefits, no reduction would apply. If he later becomes eligible for an old-age benefit under OASDI, his CSR annuity would then be reduced, using only actual Federal service after December 31, 1965, in the reduction formula.

(e) *Reduction of survivor spouse annuity (death before retirement).*—The annuity payable to the widow or dependent widower would be 55 percent of the employee's reduced annuity rather than 55 percent of the employee's full annuity. The employee's reduced annuity (on which the survivor annuity is based) would be computed in the same way as the annuity of a retired employee eligible for OASDI benefits.

(f) *Reduction of survivor annuity elected for spouse or for person with insurable interest in life of employee (death after retirement).*³—If the retired employee designated the full amount of his annuity as the basis of the survivor annuity, the reduction in the survivor annuity would be the same as in the case of death before retirement. If the retired employee designated only part of his annuity, the reduction of the survivor annuity would be proportional to the reduction that would apply in the case of a survivor annuity based on the employee's full annuity.

(g) *Elimination of survivor child annuities where OASDI benefits are payable.*—The CSR survivor child annuity would be eliminated in every case in which the employee was subject to dual coverage under OASDI and CSR.

(h) *Coordination plan guarantee.*—The plan would include a guarantee applicable only to present employees and their survivors, that the OASDI benefit and the CSR annuity together would be at least as great as the CSR annuity which would have been payable had the employee not elected dual coverage. The guarantee would, of course, apply only if the individual eligible for OASDI benefits files application for them; the guaranteed amount would be determined on the basis of OASDI benefits payable without regard to the retirement test.

*Illustrative monthly retirement benefits to single retired worker under the coverage-coordination plan*¹

Monthly pay ²	A. Work history—40 years, all in Federal service		B. Work history—32 years Federal, 8 years non-Federal service		C. Work history—25 years Federal, 15 years non-Federal service		D. Work history—15 years Federal, 25 years non-Federal service	
	Present law	Coordination	Present law	Coordination	Present law	Coordination	Present law	Coordination
\$333 (\$4,000 per annum):								
CSR.....	\$256	\$156	\$202	\$102	\$156	\$73	\$89	\$39
OASDI.....	0	112	0	112	69	112	88	112
Total.....	256	268	202	214	225	185	177	151
\$500 (\$6,000 per annum):								
CSR.....	381	261	301	191	231	131	131	71
OASDI.....	0	127	0	127	75	127	97	127
Total.....	381	388	301	308	306	258	228	198
\$833 (\$10,000 per annum):								
CSR.....	635	515	502	382	385	285	219	159
OASDI.....	0	127	0	127	75	127	97	127
Total.....	635	642	502	509	460	412	316	286

¹ Assumes employee is aged 65 when he retires.

² Average pay during 5 highest earnings years in Federal service. Average earnings under OASDI are assumed to be these amounts or \$400 per month (\$4,800 per annum), whichever is less. All employment occurs after effective date of plan.

³ Under CSR, the reduction in the employee's annuity is 2½ percent of the first \$3,600 of the amount designated plus 10 percent of the designated amount in excess of \$3,600. As now provided under CSR, the election of a survivor annuity of a spouse is automatic and the full amount of the retirement annuity is designated unless the employee specifies otherwise.

Illustrative monthly retirement benefits to retired worker and wife under the coverage-coordination plan ¹

Monthly pay ²	A. Work history—40 years, all in Federal service		B. Work history—32 years Federal, 8 years non-Federal service		C. Work history—25 years Federal, 15 years non-Federal service		D. Work history—15 years Federal, 25 years non-Federal service	
	Present law	Coordination	Present law	Coordination	Present law	Coordination	Present law	Coordination
\$333 (\$4,000 per annum):								
CSR.....	\$250	\$152	\$198	\$100	\$152	\$71	\$87	\$39
OASDI:								
Worker.....	0	112	0	112	69	112	88	112
Wife.....	0	56	0	56	35	56	44	56
Total.....	250	320	198	268	256	239	219	207
\$500 (\$6,000 per annum):								
CSR.....	366	255	294	177	225	128	128	69
OASDI:								
Worker.....	0	127	0	127	75	127	97	127
Wife.....	0	64	0	64	38	64	49	64
Total.....	366	446	294	368	338	319	274	260
\$833 (\$10,000 per annum):								
CSR.....	594	486	474	366	369	278	213	155
OASDI:								
Worker.....	0	127	0	127	75	127	97	127
Wife.....	0	64	0	64	38	64	49	64
Total.....	594	677	474	557	482	469	359	346

¹ Assumes employee and wife are both aged 65 when he retires, and that employee elects reduced CSR annuity to provide CSR survivor protection for wife. An employee who does not elect this reduction would of course, receive somewhat higher benefits than those indicated above for the retired worker, both under present law and under coordination.

² Average pay during 5 highest earnings years in Federal service. Average earnings under OASDI are assumed to be these amounts or \$400 per month (\$4,800 per annum), whichever is less. All employment occurs after effective date of plan.

SURVIVORS BENEFITS—COORDINATION PLAN

Illustrative monthly benefits payable to a widow with two minor children ⁴ of a worker who dies while in Federal employment, after 10 years of Federal service. His "high-5-year average pay" is \$6,000; his average annual earnings for OASDI purposes is \$4,800.

	System paying benefits	Present law	Coordination plan
While there are 2 minor children.....	CSR.....	\$145	\$23
	OASDI.....	0	254
Total.....		145	277
While there is 1 minor child.....	CSR.....	95	23
	OASDI.....	0	191
Total.....		95	214
While there are no minor children, widow under age 62.....	CSR.....	45	45
	OASDI.....	0	0
Total.....		45	45

Illustrative monthly benefits payable to a widow, after she reaches 62, of a worker who dies in Federal employment, after 25 years of Federal service. His

⁴ Child's benefits under social security terminate when the child reaches age 18. Benefits to a widow under age 62 terminate when there are no longer any children of the worker under age 18. Child's benefits under CSR terminate generally at age 18, unless the child is a student, in which case benefits continue up to age 21. Widow's benefits under CSR are payable regardless of the age of the widow or whether or not there are still children of the worker under age 21.

"high-5-year average pay" is \$6,000; his average annual earnings for OASDI purposes is \$4,800.

System paying benefits	Present law	Coordination plan
CSR.....	\$127	¹ \$72
OASDI.....	0	105
Total.....	127	177

¹ Widow's benefits under civil service retirement begin when the employee dies, regardless of the age of the widow. There would be no reduction of such benefits for periods when there is no eligibility for OASDI benefits.

APPENDIX E

RECOMMENDATIONS OF THE KAPLAN COMMITTEE ⁵ FOR EXTENSION OF SOCIAL SECURITY COVERAGE TO EMPLOYMENT COVERED BY THE FEDERAL CIVIL SERVICE RETIREMENT SYSTEM

The plan for extending social security coverage to employment covered by the civil service retirement system which was recommended by the Kaplan Committee in 1954 must of course be considered in light of the provisions of the CSR and OASI programs at that time. Major changes in the two programs since 1954 have made a number of specific recommendations of the Kaplan Committee obsolete.

The more important changes have been made in the CSR provisions (by legislation enacted in 1956 and 1962) ⁶ are: (a) increase in the basic annuity formula from 1½ percent of high-5-year average pay for each year of service to 1½ percent for each of the first 5 years of service, 1¼ percent for each of the next 5 years, and 2 percent for each year of service after the 10th; (b) provision of a guarantee (generally speaking) of 40 percent of high-5-year average pay for employees qualifying for disability annuities; (c) improvement of survivor annuities; (d) provision for automatic cost-of-living increases for annuitants; and (e) increase in the employee contribution rate to 6½ percent of pay, compared with 6 percent in 1954. In 1954, the cost of the CSR system was estimated at 15.70 percent of payroll—11.15 percent was the normal cost and 4.55 percent was a deficiency arising from past costs for which no contributions were obtained (known as the unfunded accrued liability). The present estimate of the cost of the system is 22.33 percent of payroll—13.49 percent normal cost and 8.84 percent deficiency cost.

The committee's recommendations contemplated the enactment of the 1954 social security amendments, then under consideration in the Congress, but, of course, did not anticipate the subsequent changes. Among the changes made in social security after the enactment of the 1954 amendments are: (a) increase in social security benefit levels through a change in the benefit formula as well as an increase in the amount of covered earnings to \$4,800 from \$4,200; (b) lowering the requirements for fully insured status; (c) addition of disability insurance benefits; (d) easing of the retirement test; (e) provision for benefits at age 62 (generally on an actuarially reduced basis); and (f) increase in the ultimate employee and employer contribution rate from 4 percent each reached in 1975 to 4½ percent each reached in 1968.

Following the 1954 amendments, the level-premium cost of the social security program was estimated on an intermediate cost basis as 7.45 percent of taxable payroll. The cost of the present program is estimated at 9.33 percent of taxable payroll. Among other things which have helped to outdate the 1954 recommendations are the greatly increased period of time elapsing since the social security "new start" (Jan. 1, 1951) for computing benefit amounts and insured status.

⁵ The Committee on Retirement Policy for Federal Personnel, established pursuant to Public Law 555 82d Cong., to make a comparative study of retirement systems for Federal personnel and to report to the Congress its findings and recommendations. The Committee consisted of high officials of the executive branch of the Government with the exception of the Chairman, H. Eliot Kaplan. Its report was submitted May 20, 1954.

⁶ Public Law 854, approved July 31, 1956, and Public Law 87-793, approved Oct. 11 1962.

The following example, based on the case of an employee retiring at age 65 after 30 years of Federal service with \$6,000 salary, illustrates the effects of some of the changes made since 1954.

	Employee's monthly benefit	Wife's benefit
1954 CSR law.....	\$225	0
1954 Kaplan plan, CSR and OASI.....	245	\$42
1963 CSR law.....	281	0
1963 CSR and OASDI, if CSR were reduced by same percentage of pay as under Kaplan plan.....	319	50

General recommendations of the Kaplan plan.—All active members of the CSR system (except Congressmen and congressional employees) would have been covered by both CSR and OASI effective January 1, 1956.

The adjusted CSR formula,⁷ to be applied in all cases where an OASI benefit based on Federal service was also payable, would have been: 1 percent of the first \$5,000 of high-5-year average pay plus 1½ percent of such pay in excess of \$5,000, multiplied by years of service. In this connection, two points should be noted: (a) the \$5,000 figure was recommended despite the fact that the anticipated OASI earnings base was \$4,200, and (b) in cases where the proposed formula was applicable, it was intended to be applied to all years of service, including service prior to the effective date of the plan.

The proposed change in the CSR annuity formula would not have affected anyone who retired or otherwise terminated his Federal service before January 1, 1956. Only those who completed enough Federal civilian service covered by OASI to be "insured" for OASI benefits were to be subject to the new CSR annuity formula. (At the time, to be fully insured under OASI a worker was required to have half as many quarters of coverage as the number of calendar quarters elapsing after 1950 (or age 21, if later) and before age 65, with a minimum of 6 quarters of coverage.)

Under the proposed plan, the minimum number of years of service for eligibility under CSR for survivor protection or for a deferred retirement annuity would have been increased (from 5 years of service) to 10 years of service.

The proposed plan included a guarantee that the total benefit based on Federal service (i.e., the reduced CSR annuity plus the social security benefit based on Federal service) would in no case be less than the benefit which would have been payable by the CSR system under provisions then in effect.

Age and service retirement annuity.—No change was proposed in the computation of retirement annuities payable prior to age 65. The modified CSR formula, mentioned earlier, would have been applicable in respect to all such annuity amounts payable at or after age 65 if the annuitant was insured under OASI on the basis of his Federal service.

Following are illustrative monthly retirement benefits, payable after age 65 under the CSR formula as existing in 1954 and as proposed by the Kaplan Committee. Where high-5-year average pay was in excess of \$4,800, the increase in benefits under the plan would have been in the same absolute dollar amounts as in the \$4,800 case.

High-5-year average pay	20 years' service			30 years' service		
	Existing	Proposed		Existing	Proposed	
		Worker	Wife		Worker	Wife
\$4,200.....	\$112	\$123	\$27	\$168	\$185	\$40
\$4,800.....	122	135	28	183	203	42

As indicated, no benefit was (nor is now) provided under CSR for the wife of a retired employee. Under the proposed plan, the social security benefits for a wife (or dependent husband) would have been available when the wife attained age 65.

⁷ As noted, in 1954 the basic CSR benefit formula for computing retirement disability, and (indirectly) survivor annuities was: 1½ percent of high-5-year average pay, multiplied by the employee's years of service. The CSR law provided a more favorable formula for computing annuities of employees high-5-year average earnings were below \$5,000 per year. The 1954 recommendation included a proposed method, not discussed here, of providing equitable adjustments in CSR benefits computed under the alternative formula.

It was estimated that under the plan retirement benefit amounts based on Federal employment would be increased, on the average, by about 8 percent after age 65. The percentage increase would have been smaller, of course, for employees in the higher salary range. However, the combined benefits for a retired employee and his wife after both reached age 65 would have exceeded the existing CSR benefit by as much as 30 percent for those with low salary bases, and by 20 percent for those with a high-5-year average of \$8,000.

Disability retirement.—Inasmuch as disability insurance benefits had not been provided under social security by 1954, no changes in the CSR disability provisions were recommended in connection with the coordination plan.

Survivor protection.—Among the principal changes recommended were (a) the widow's CSR annuity amount was to be half of the retirement annuity, computed under the new formula instead of the existing formula, earned by the employee up to the time of death; (b) elimination of the CSR annuities for surviving children; (c) making the widow's CSR annuity payable immediately (instead of at age 50) when no children survived; and (d) upon election by a retired employee of a reduced annuity to provide a survivor annuity in case of his death, the reduction would be on an actuarial basis, resulting in a greater reduction than under the provisions then in effect.

Despite the proposed cutbacks in survivor protection provided under CSR, the net result of these changes and the addition of social security survivor benefits would have been a very substantial improvement in the survivor protection of Federal workers.

Period of transition.—Several special provisions were proposed—principally a guarantee of social security survivor protection—to be effective temporarily in the period after the coordination plan was adopted to make it fully effective without delay.

Employee contributions.—The then existing employee contribution rate under CSR of 6 percent would have been continued for that part of an employee's salary in excess of \$4,200 a year (the OASI earnings base) and would have been reduced to 3½ percent with respect to salary of \$4,200 or less. In addition the employee (and the Government, as employer) would have paid social security contributions—then 2 percent of the first \$4,200 of pay, and scheduled to rise, ultimately, to 4 percent.

Cost effects.—It was estimated that after 1954 under the proposed plan, the reduce "normal" cost (average cost for new entrants) of the CSR system plus employer and employee social security contributions would reach an amount about 3½ percent of payroll in excess of the 1954 normal cost of CSR. The "unfunded accrued liability" of the CSR system (estimated by the CSR Board of Actuaries to be 4.55 percent of payroll as of June 30, 1954) would, however, have been reduced by about one-third so that the net added cost was estimated at about 2 percent of payroll. Some savings would also have accrued to the OASI system (the saving was estimated in 1954 at about 0.05 percent of covered payroll) by reason of the broadening of social security coverage proposed under the plan.

Administration proposal.—The Administration approved the coordination plan and, in January 1956, the Civil Service Commission transmitted to Congress proposed legislation that substantially embodied recommendations of the Kaplan Committee for extending OASI coverage to employment covered by the CSR system. However, the bill (S. 3041), introduced January 25, 1956, by Senator Frank Carlson, ranking minority (Republican) member of the Senate Post Office and Civil Service Committee, was not reported out.

APPENDIX F

A TRANSFER-OF-CREDIT PLAN WHICH FOLLOWS APPROACH No. 5

Credit would be transferred from the civil service retirement system to social security for the Federal service of—

(1) People who die, become disabled, or separate from work covered under the civil service retirement system after less than 5 years of Federal service. Example: Worker becomes totally disabled or dies after working one year in work covered by social security and then 4 years under civil service retirement. Under present law no monthly benefits would be payable under civil service retirement or social security. Under the transfer-of-credit plan, if he were disabled he would get monthly social security benefits of \$127, and if he

has a wife and child, the family would get benefits of \$254; if he died his widow and child would get a monthly social security benefit of \$191.⁸

(2) People who separate after 5 or more years of Federal work and obtain refunds of their contributions to the civil service retirement system. Example: Worker has 6 years of employment under the civil service retirement system, and separates, taking a refund of civil service retirement contributions. He then works one year under social security, and then dies. Under present law, no monthly benefits would be payable under civil service retirement or social security to his widow and two children. Under the transfer-of-credit plan, monthly social security benefits of \$254 would be payable to the surviving family.⁸

(3) People who separate after 5 or more years of Federal work and do not take refunds of their contributions to the civil service retirement system, if such persons die before age 62. As in the preceding example, under present law no monthly benefits would be payable under civil service retirement or social security to the worker's widow and two children; under the transfer-of-credit plan, monthly social security benefits of \$254 would be payable to the surviving family.⁸

The transfer-of-credit plan would be applicable to Federal employment performed on or after a specified future date, such as the first day of the year following the enactment of legislation. For those in Federal employment on the effective date the plan would also be applicable to employment during the preceding 1½ year period, thus assuring immediate survivor protection for the families of such workers.

COSTS

The costs of this transfer-of-credit plan has been estimated on the assumption that the cost of the benefits resulting from the plan would be roughly equivalent to the value of employer and employee social security contributions on earnings for which credit would be transferred—that is, the contributions which would be payable if such earnings were covered under social security instead of the civil service retirement system when the work was performed. On this basis, the long-run cost of the plan for the Government, as employer, would be about \$75 million annually, or about one-half of 1 percent of payroll.⁹

About half of the cost of the plan would be borne by those workers who would have credit for their Federal employment transferred to social security under the plan—those who separate from Federal service and receive refunds of their contributions to the civil service retirement system, or who die or become disabled while employed but before completing 5 years of Federal service. In all such cases, the civil service retirement system would deduct from the refunds an amount equal to the social security contributions which the worker would have been required to pay if his Federal employment had been covered under social security. The additional protection which the plan would provide for career employees during their early years of Federal service—social security credit for survivorship and disability protection during the first 5 years of service—would be provided without additional cost to them.

Appropriate arrangements would be developed by the agencies concerned for the transfer to the social security trust funds of amounts sufficient to meet the proportionate cost, attributable to Federal employment, of social security benefits which would be paid as a result of the transfer-of-credit plan. The proportion of the cost attributable to Federal employment would be the ratio that the dollar amount of a worker's transferred credits bears to his total social security earnings credits after the transfer.

CHARTS SHOWING BENEFIT AMOUNTS PAYABLE IN ILLUSTRATIVE CASES UNDER PRESENT LAW, AND UNDER A TRANSFER-OF-CREDIT PLAN¹⁰

The charts on the following pages illustrate the effect of the transfer-of-credit plan in cases involving various combinations of work under social security and the civil service retirement system (referred to as OASDI and CSR, respectively, in the charts).

⁸ Computations are based on assumed earnings of \$4,800 a year in civil service retirement or social security work.

⁹ This estimate is of course based on present social security law, providing for social security employer and employee contributions on the first \$4,800 of an employee's annual covered earnings. Contributions rates for employer and employee are 3½ percent each for 1964-65, 4½ percent for 1966-67, and 4¾ percent for 1968 and after.

¹⁰ The transfer-of-credit plan which is described on pp. 28 and 29 of this appendix.

In all cases, it is assumed that the plan has been in operation over the entire work lifetime of the individual, and that he earns at least \$4,800 each year (the maximum amount creditable under social security under present law). It is also assumed that the individuals begin working at age 22, with the exception of case G, in which a female worker begins employment at age 18.

In none of the cases would monthly benefits be payable under the civil service retirement system; if such benefits were payable, the transfer-of-credit plan would not apply. In all cases the employee's contributions (including interest, if Federal service was less than 5 years) to the civil service retirement system are refunded, either to the separated employee or the survivors of the deceased employee or former employee. Under the transfer-of-credit plan, the amount refunded would be reduced by an amount equal to the social security contributions the employee would have paid if his Federal employment had been covered under social security.

The following social security benefits are payable to insured workers, their dependents, and survivors. Survivors monthly benefits are payable to a widow (or dependent divorced wife) who is caring for the worker's child entitled to benefits, to a dependent child, and, at age 62, to a widow, dependent widower, or dependent parent. A lump-sum death payment is also made. Disability monthly benefits are payable to a worker, to his dependent child, and to his wife if she is caring for a child beneficiary or if she has reached age 62. Retirement monthly benefits are payable to a retired worker, his wife (or dependent husband) at age 62, a dependent child, and a wife who has not reached age 62 if she is caring for a child beneficiary. A worker may elect to have his social security retirement benefits begin as early as age 62, but the amount of the monthly benefit is reduced according to the number of months that the benefit will be paid before the worker reaches age 65. A worker receiving disability benefits is transferred to the old-age insurance beneficiary roll (with the same benefit amount) at age 65. Social security benefits of persons who have not reached age 72 and who earn more than \$1,200 in a year are reduced by \$1 for each \$2 earned from \$1,200 to \$1,700, and by \$1 for each \$1 of earnings over \$1,700.

Case A

Mr. A works 1 year under OASDI. He then works 4 years under CSR when it is assumed that he (1) becomes disabled, or (2) dies.

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 1 child
		Worker alone	Worker, wife and 1 child	
Present law	CSR	1 0	1 0	1 0
	OASDI	0	0	0
Transfer-of-credit plan	CSR	2 0	2 0	2 0
	OASDI	\$127	\$254	\$191

¹ No annuity benefit. Lump-sum refund of employee's CSR contributions plus interest.

² No annuity benefit. Reduced lump-sum refund (employees' CSR contributions plus interest, reduced for employee OASDI taxes).

Case B

Mr. B works 2 years under CSR. He then separates from his Government job because of a severe disability and dies before he attains age 30.

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 1 child
		Worker alone	Worker, wife and 1 child	
Present law	CSR	1 0	1 0	1 0
	OASDI	0	0	0
Transfer-of-credit plan	CSR	2 0	2 0	2 0
	OASDI	0	0	³ \$191

¹ No annuity benefit. Lump-sum refund of employee's CSR contributions plus interest.

² No annuity benefit. Reduced lump-sum refund (employee's CSR contributions plus interest, reduced for employee OASDI taxes).

³ Based on his 8 quarters of coverage, the worker also has OASDI survivorship protection in his 30th year, but for a smaller benefit amount (\$147 for a widow and 1 child) but he is not insured if he dies at age 31 or later.

Case C

Mr. C works 12 years under CSR. He then separates from his Government job, taking a refund of his contributions, and works 12 years under OASDI, when it is assumed that he (1) becomes disabled, or (2) dies.

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 2 children
		Worker alone	Worker, wife, and 2 children	
Present law.....	CSR.....	1 0	1 0	1 0
	OASDI.....	\$95	\$203	\$203
Transfer-of-credit plan.....	CSR.....	2 0	2 0	2 0
	OASDI.....	127	254	254

¹ No annuity benefit. Lump-sum refund of employees' CSR contributions, without interest.

² No annuity benefit. Reduced lump-sum refund (employee's CSR contributions without interest, reduced for employee OASDI taxes).

NOTE.—80 percent of male workers with 10 to 19 years of Federal service unbroken by any refund of CSR contributions who separate between the ages of 30 to 39 years claim a CSR refund within 6 months of separation.

Source: Social Security Administration Analytical Note No. 6-61.

Case D

Mr. D works 12 years under CSR. He then separates from his Government job, not taking a refund of his contributions, and works 12 years under OASDI, when it is assumed that he (1) becomes disabled, or (2) dies. (Identical to case C except no refund.)

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 2 children
		Worker alone	Worker, wife, and 2 children	
Present law.....	CSR.....	1 0	1 0	2 0
	OASDI.....	\$95	\$203	\$203
Transfer-of-credit plan.....	CSR.....	3 0	3 0	4 0
	OASDI.....	95	203	254

¹ If no refund is elected before age 62, worker is entitled to monthly CSR benefit of \$81 if he attains that age.

² Survivor receives lump-sum refund of employee's CSR contributions, without interest.

³ Same benefit as in footnote 1, but if, before age 62, a reduced lump-sum refund is elected (forfeiting CSR benefit at age 62), OASDI benefit becomes \$127 (worker alone) or \$254 (worker and family).

⁴ Survivor receives reduced lump-sum refund (employee's CSR contributions without interest, reduced for employee OASDI taxes).

Case E

Mrs. E works 12 years under CSR. She then separates from her Government job to become a housewife and takes a refund of her contributions.

	System paying benefits	Monthly disability benefits		Monthly retirement benefits, at age 62
		Disabled 0 to 5 years after separation	Disabled more than 5 years after separation	
Present law.....	CSR.....	1 0	1 0	1 0
	OASDI.....	0	0	0
Transfer-of-credit plan.....	CSR.....	2 0	2 0	2 0
	OASDI.....	127	0	3 57

¹ Lump-sum refund of employee's CSR contributions, without interest.

² Reduced lump-sum refund (employee's CSR contributions, without interest, reduced for employee OASDI taxes).

³ Worker's basic benefit amount of \$71 actuarially reduced because of retirement at age 62.

NOTE.—70 percent of female workers with 10 to 19 years of Federal service unbroken by any refund of CSR contributions who separate between the ages of 30 to 39 claim a CSR refund within 6 months of separation.

Source: Social Security Administration Analytical Note No. 6-61.

Case F

Mr. F works 2 years under OASDI. He then works 10 years under CSR, separates from his Government job, and takes a refund. He then works 1 year under OASDI, when it is assumed that he (1) becomes disabled, or (2) dies.

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 1 child
		Worker alone	Worker, wife and 1 child	
Present law.....	CSR.....	10	10	10
	OASDI ²	0	0	0
Transfer-of-credit plan.....	CSR.....	30	30	30
	OASDI.....	\$127	\$254	\$191

¹ Lump-sum refund of employee's CSR contributions, without interest.

² Under OASDI, worker is not insured for disability because he does not meet the requirement of 20 quarters' coverage during the 40 quarters preceding quarter of disability. He is not insured for survivor benefits because he is not fully insured (needs 13 quarters of coverage; has 12), and is not currently insured (6 quarters of last 13 before quarter of disability or death).

³ Reduced lump-sum refund (employee's CSR contributions, without interest, reduced for employee OASDI taxes).

NOTE.—80 percent of male workers with 10 to 19 years of Federal service unbroken by any refund of CSR contributions who separate between the ages of 30 to 39 years claim a CSR refund within 6 months of separation.

Source: Social Security Administration Analytical Note No. 6-61.

Case G

Mr. G works 2 years under OASDI. He then works 10 years under CSR, separates from his Government job, and does not take a refund. He then works 1 year under OASDI, when it is assumed that he (1) becomes disabled, or (2) dies. (Identical to case F except no refund.)

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 1 child
		Worker alone	Worker, wife, and 1 child	
Present law.....	CSR.....	10	10	20
	OASDI.....	0	0	0
Transfer-of-credit plan.....	CSR.....	30	30	40
	OASDI.....	0	0	\$191

¹ If no refund is elected before age 62, worker is entitled to monthly benefit of \$65 if he attains that age.

² Survivor receives lump-sum refund of employee's CSR contributions, without interest.

³ Same benefit as in footnote 1, but if, before age 62, a reduced lump-sum refund is elected (forfeiting CSR benefit at age 62), OASDI benefit becomes \$127 (worker alone) or \$254 (worker and family).

⁴ Survivor receives reduced lump-sum refund (employee's CSR contributions, without interest, reduced for employee OASDI taxes).

Case H

Mr. H works 24 years under CSR. He then separates from his Government job, taking a refund, and works 12 years under OASDI, when it is assumed that he (1) becomes disabled, or (2) dies.

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 1 child
		Worker alone	Worker, wife and 1 child	
Present Law.....	CSR.....	10	10	10
	OASDI.....	\$74	\$124	\$111
Transfer-of-credit plan.....	CSR.....	20	20	20
	OASDI.....	127	254	191

¹ Lump-sum refund of employee's CSR contributions, without interest.

² Reduced lump-sum refund (employee's CSR contributions, without interest, reduced for employee OASDI taxes).

NOTE.—55 percent of male workers with 20 to 29 years of Federal service unbroken by any refund of CSR contributions who separate between the ages of 40 and 49 claim a CSR refund within 6 months of separation.

Source: Social Security Administration Analytical Note No. 6-61.

Case I

Mr. I works 24 years under CSR. He then separates from his Government job, not taking a refund, and works 12 years under OASDI, when it is assumed that he (1) becomes disabled, or (2) dies. (Identical to case H except no refund.)

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 1 child
		Worker alone	Worker, wife, and 1 child	
Present law	CSR	1 0	1 0	2 0
	OASDI	\$74	\$124	\$111
Transfer-of-credit plan	CSR	3 0	3 0	4 0
	OASDI	74	124	191

¹ If no refund is elected before age 62, worker is entitled to monthly benefit of \$177 if he attains that age.

² Survivor receives lump-sum refund of employee's CSR contributions, without interest.

³ Same benefit as in footnote 1, but if, before age 62, a reduced lump-sum refund is elected (forfeiting CSR benefit at age 62), OASDI benefit becomes \$127 (worker alone) or \$254 (worker and family).

⁴ Survivor receives reduced lump-sum benefit (employee's CSR contributions, without interest, reduced for employee OASDI taxes).

Case J

Mrs. J starts working at age 18 and works 4 years under CSR. She then separates from her Government job. After 6 years at home, she works 2 years under OASDI, when it is assumed that she (1) becomes disabled, or (2) dies.

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, 2 children ¹
		Worker alone	Worker, and 2 children	
Present law	CSR	2 0	2 0	2 0
	OASDI ²	0	0	\$147
Transfer-of-credit plan	CSR	4 0	0	0
	OASDI	\$127	\$254	191

¹ Worker's husband not dependent on her.

² No annuity benefit. Lump-sum refund of employee's CSR contributions plus interest.

³ Worker not entitled to social security disability benefits, but is currently insured so as to entitle children to survivors benefits.

⁴ No annuity benefit. Reduced lump-sum refund (employee's CSR contributions plus interest, reduced for employee OASDI taxes).

Case K

Mr. K works 16 years under CSR. He then separates from his Government job, taking a refund, and works for 4 years for a municipality in a position not covered under OASDI, after which he works under OASDI until he attains age 60 (18 years). He applies for retirement benefits under OASDI at age 62.

	System paying benefits	Monthly retirement benefits	
		Worker alone	Worker and wife at age 62
Present law	CSR	1 0	1 0
	OASDI ²	\$47	\$66
Transfer-of-credit plan	CSR	3 0	3 0
	OASDI ³	94	139

¹ Lump-sum refund of employee's CSR contributions, without interest.

² Benefit amounts have been actuarially reduced because of retirement at age 62 instead of age 65. The worker's unreduced benefit amount at age 65 under present law would be \$59, and under a transfer-of-credit plan \$118.

³ Reduced lump-sum refund (employee's CSR contributions, without interest, reduced for employee OASDI taxes).

NOTE.—80 percent of male workers with 10 to 19 years of Federal service unbroken by any refund of CSR contributions who separate between the ages of 30 and 39 years claim refund within 6 months of separation.

Source: Social Security Administration Analytical Note No. 6-61.

APPENDIX G

RECOMMENDATION REGARDING FEDERAL EMPLOYMENT IN REPORT OF
THE ADVISORY COUNCIL ON SOCIAL SECURITY ¹¹

Social security credit should be provided for the Federal employment of workers whose Federal service was covered under the civil service retirement system but who are not protected under that system at the time they retire, become disabled, or die.

Unlike almost all private pension plans and a high proportion of State and local retirement systems, the Federal civil service retirement system is not supplementary to the social security program. Thus when a person leaves Federal employment, his years of previous Federal service do not count toward social security benefits. Moreover, protection under the civil service retirement system does not start until after 5 years of Federal employment. As a result, although the civil service retirement system provides good protection for people who stay in Federal employment, Federal workers who leave, or those who die or become disabled before having worked for the Government for 5 years, may have inadequate protection or none at all under either civil service retirement or social security.

A practicable and relatively inexpensive way of filling the most serious gaps that result from this situation is to provide for social security credit for the Federal employment of those workers who are not protected under the civil service system at the time they retire, become disabled, or die. As part of the financing arrangement, the civil service retirement system would withhold, from the returns of contributions that are made from the civil service retirement system to separating employees, amounts equal to the social security employee contributions which would have been payable if their Federal work had been covered under social security. These withholdings would be transferred to the social security fund and additional financial adjustments made between the two systems to take account of the transfers of credit.

The plan includes the following principal elements, all of which the Council considers essential to its effective operation:

(1) Credit would be transferred to social security for the Federal service of individuals who die, become disabled, or separate from work covered under the civil service retirement system after less than 5 years of Federal service. (At present, the only provision made where a person with less than 5 years of service dies or terminates his employment is for a refund of employee contributions.)

(2) Credit would be transferred to social security for the Federal service of people who separate after 5 or more years of Federal work and obtain refunds of their contributions to the civil service retirement system. (The civil service retirement system does not provide any protection for people who separate from the civil service and take refunds.)

(3) Former civil service employees who have not taken refunds of their civil service contributions and who die or who become disabled before age 62 could have credit for their Federal service transferred to social security. (Former employees do not have disability or survivorship protection under the civil service retirement system after separation.)

This transfer-of-credit approach would forgo certain advantages which would be achieved by a straight extension of social security coverage. For example, an extension of social security coverage would provide superior protection for workers who become disabled or die relatively early in their careers. However, the transfer-of-credit approach the Council is suggesting would be considerably less costly for the Federal Government than a straight extension of social security coverage. Equally important, whereas an extension of social security coverage would require substantial modification of the civil service retirement system to take account of social security benefits and contributions, no modifications would be required to carry out the Council's recommendation except for the financing of the transfer of credits.

¹¹ "The Status of the Social Security Program and Recommendations for Its Improvement," report of the Advisory Council on Social Security, Washington, D.C., 1965 (pp. 79-81).

APPENDIX H

OPERATION OF THE RAILROAD RETIREMENT-SOCIAL SECURITY MINIMUM PROVISION IF APPLIED TO THE CIVIL SERVICE RETIREMENT SYSTEM ¹²

As part of the social security-railroad coordination a railroad worker is assured, under a minimum guarantee provision, that the total amount of the annuities paid to him and his family will not be less in any month than 110 percent of the amount they would have received if the employee's railroad service after 1936 had been covered under social security. The following discussion indicates the effects of applying this kind of guarantee to the civil service retirement system (modified as indicated in ¹²) as an addition to provisions of approach No. 5.

DEATH OR DISABILITY IN SERVICE

As the attached tables show, the social security minimum provision would have a great effect upon these types of civil service annuities in many cases. The guarantee would be particularly helpful in cases where the death or disability occurs before the worker nears retirement age, and where he leaves a widow who has children under age 18. Where the worker dies in service leaving a widow but no children, the guarantee could have no effect until the widow reaches age 62, as social security does not provide benefits for widows without children before that age. Where a worker becomes disabled and has a wife but no children the guarantee could have some immediate effect as social security pays disability benefits to workers in such situations; however, the guarantee would have much less effect than when the disabled worker had a wife and young children, as social security would also pay dependents benefits in such cases.

The cases all assume continuous Federal work since age 22. This was done in the interest of simplicity, and also because such cases are the most representative. However, if the worker qualified for an OASDI benefit on the basis of non-Federal work the social security minimum provision would have much less effect, or no effect, on the civil service retirement system annuity amounts. The worker could of course qualify for OASDI benefits through non-Federal work done before his Federal service, during breaks in his Federal service, or by part-time jobs while in Federal service.

RETIREMENT, AND DEATH AFTER RETIREMENT

Over the long-run (i.e., after the effect of the 1950 new start wears off) the social security minimum provision would have very little effect in these types of cases, and consequently no benefit tables are presented. Civil service benefits for career civil service workers, and for their widows in cases of death after retirement, would almost always be higher than the amount of the social security minimum. Short-term civil service workers would ordinarily qualify for OASDI benefits based on non-Federal work, and so the social security minimum would not increase the civil service annuity. (Almost all married civil service annuitants provide at least \$3,600 of their civil service retirement annuity—or all of it if it is lower—as the base for widow's benefits, and the above is based on the assumption this practice would continue. Some provision might be needed to prevent the protection provided under the social security minimum from leading retirees to decide not to choose to come under the present civil service retirement provisions for providing widow's annuities.)

RELATIONSHIP TO THE SOCIAL SECURITY MINIMUM PROVISIONS OF THE RAILROAD RETIREMENT ACT

It would seem necessary to have provisions in both the Railroad Retirement and Civil Service Acts to coordinate the operation of the two minimum provisions in the case of persons with both railroad and civil service work. Otherwise, the widow and children of an individual, for example, who worked 10 years under the Railroad Retirement Act and 5 years under civil service could receive an annuity under the Railroad Retirement Act equal to the maximum benefit payable under the Social Security Act, and a very substantial annuity under the civil service system based on the social security minimum. If the worker had several children, the survivors could, in the absence of coordinating provisions, receive the Social Security Act maximum under both programs.

¹² It is assumed, in both the discussion and examples, that the social security minimum provision, if applied to the civil service retirement system, would be applied as 100 percent (rather than 110 percent, as under the railroad program) of the benefits as computed under the social security benefit formula.

ADMINISTRATION

The administration of the social security minimum provision is relatively difficult, and involves much exchange of information between the railroad retirement and social security programs. The railroad retirement staff of course must make continuing computations and recomputations under the social security benefit provisions, and must take account of the operation of the social security retirement test, and other social security provisions affecting social security benefit amounts. The railroad retirement system must know not only about OASDI benefits actually payable, but also about OASDI benefits which a railroad retirement annuitant is eligible for but has not filed for, as the social security minimum provision takes account of OASDI benefits payable, whether or not the individual has claimed them.

CIVIL SERVICE SURVIVORS BENEFITS—SOCIAL SECURITY MINIMUM PROVISIONS

TABLE 1.—*Illustrative monthly benefits payable to a widow with 1 minor child where the worker dies while in Federal employment*¹

CSR average pay ²	Years of Federal service					
	5	10	15	20	25	30
\$4,000:						
Present law.....	\$65	\$81	\$99	\$118	\$136	\$154
Social security minimum.....	168	168	168	168	168	168
\$6,000:						
Present law.....	71	95	122	150	177	205
Social security minimum.....	191	191	191	191	191	(³)
\$10,000:						
Present law.....	85	124	170	216	262	308
Social security minimum.....	191	191	191	(³)	(³)	(³)

¹ It is assumed the worker enters Federal service at age 22 and works continuously in Federal service until his death.

² Average pay during 5 highest earnings years in Federal service. Average earnings under OASDI are assumed to be this amount or \$4,800, whichever is less.

³ Not effective.

NOTE.—CSR benefits are payable to a widow regardless of her age. Social security benefits are payable to a widow under age 62 only if she has in her care a child of the worker who is entitled to social security benefits, so the social security minimum would not operate where the widow is under age 62 and has no children under age 18.

TABLE 2.—*Illustrative monthly benefits payable to a widow with 2 minor children where the worker dies while in Federal employment*¹

CSR average pay ²	Years of Federal service					
	5	10	15	20	25	30
\$4,000:						
Present law.....	\$115	\$131	\$149	\$168	\$186	\$204
Social security minimum.....	252	252	252	252	252	252
\$6,000:						
Present law.....	121	145	172	200	227	255
Social security minimum.....	254	254	254	254	254	(³)
\$10,000:						
Present law.....	135	174	220	266	312	358
Social security minimum.....	254	254	254	(³)	(³)	(³)

¹ It is assumed the worker enters Federal service at age 22 and works continuously in Federal service until his death.

² Average pay during 5 highest earnings years in Federal service. Average earnings under OASDI are assumed to be this amount or \$4,800, whichever is less.

³ Not effective.

See note, table 1.

CIVIL SERVICE DISABILITY BENEFITS—SOCIAL SECURITY MINIMUM PROVISIONS

TABLE 3.—*Illustrative monthly benefits payable to a disabled worker with wife and 1 child¹ where the worker becomes disabled while in Federal employment²*

CSR average pay ³	Years of Federal service					
	5	10	15	20	25	30
\$4,000:						
Present law.....	\$133	\$133	\$133	\$133	\$156	\$190
Social security minimum.....	224	224	224	224	224	224
\$6,000:						
Present law.....	200	200	200	200	231	281
Social security minimum.....	254	254	254	254	254	(⁴)
\$10,000:						
Present law.....	333	333	333	333	385	469
Social security minimum.....	(⁴)	(⁴)	(⁴)	(⁴)	(⁴)	(⁴)

¹ Where worker has no dependent child and his wife is below retirement age, the social security minimum would not produce a higher benefit.

² It is assumed that he enters Federal service at age 22 and works continuously in Federal service until disablement.

³ Average pay during 5 highest earnings years in Federal service. Average earnings under OASDI are assumed to be this amount or \$4,800, whichever is less.

⁴ Not effective.

NOTE.—There is no provision under CSR for the payment of benefits to dependents of a retired or disabled worker. Social security benefits are payable to the wife of a retired or disabled worker beginning at age 62, or under age 62 if she has in her care a child of the worker who is entitled to social security benefits. Social security benefits are payable to children under age 18 or over age 18 if disabled before that age. The social security minimum would have no effect where the worker has no dependent child and his wife is below retirement age because it would not produce benefits as high as those payable under the CSR benefit formula.

TABLE 4.—*Illustrative monthly benefits payable to a disabled worker with wife and 2 children¹ where the worker becomes disabled while in Federal employment²*

CSR average pay ³	Years of Federal service					
	5	10	15	20	25	30
\$4,000:						
Present law.....	\$133	\$133	\$133	\$133	\$156	\$190
Social security minimum.....	254	254	254	254	254	254
\$6,000:						
Present law.....	200	200	200	200	231	281
Social security minimum.....	254	254	254	254	254	(⁴)
\$10,000:						
Present law.....	333	333	333	333	385	469
Social security minimum.....	(⁴)	(⁴)	(⁴)	(⁴)	(⁴)	(⁴)

¹ Where worker has no dependent child and his wife is below retirement age, the social security minimum would not produce a higher benefit.

² It is assumed that he enters Federal service at age 22 and works continuously in Federal service until disablement.

³ Average pay during 5 highest earnings years in Federal service. Average earnings under OASDI are assumed to be this amount or \$4,800, whichever is less.

⁴ Not effective.

See note, table 3.



FEDERAL STATUTORY SALARY SYSTEMS

MESSAGE

FROM

THE PRESIDENT OF THE UNITED STATES

TRANSMITTING

THE JOINT ANNUAL REPORT OF THE DIRECTOR OF THE
BUREAU OF THE BUDGET AND THE CHAIRMAN OF
THE CIVIL SERVICE COMMISSION AND THE
REPORT OF THE CABINET COMMITTEE
ON FEDERAL STAFF RETIREMENT
SYSTEMS



MARCH 7, 1966.—Referred to the Committee on Post Office and Civil
Service, and ordered to be printed with accompanying papers

WASHINGTON : 1966

LETTER OF TRANSMITTAL

To the Congress of the United States:

Among the many blessings which Americans can count is a corps of Federal civil servants that is unequalled anywhere in the world. Honest, intelligent, efficient, and—above all—dedicated, these men and women represent a national resource and a national asset.

America expects much of these public servants. We have made vigorous demands on their time and energy. We have exacted from them high standards of work and conduct.

In recent years, we have moved steadily to compensate these men and women equitably and competitively for their quality performance in the public interest. To that end, the administration prepared and the Congress enacted, the Federal Salary Reform Act of 1962. We established the principle that Government workers are entitled to a pay scale which compares favorably with pay in private industry.

Such a pay scale is as much in the national interest as it is in the interest of Government employees. I said when signing the Government Employees Salary Reform Act of 1964:

America's challenges cannot be met in this modern world by mediocrity, at any level, public or private. All through our society we must search for brilliance, welcome genius, strive for excellence.

We have been true to the principle of comparability.

Since 1961, the pay of Federal employees has increased by over 16 percent.

In the brief period since I have been President, employees of the Federal Government have enjoyed pay increases amounting to nearly 12 percent. These increases have done much to close the gap between compensation for Government employees and those in private enterprise.

The increases in basic pay, however, were not accompanied by any significant benefits in forms other than salary. Yet pay, retirement, and other fringe benefits are all parts of an employee's total compensation. Recognition of this basic fact is crucial in developing a rational and equitable system of compensation. Neither pay, nor retirement, nor other fringe benefits can be considered in isolation. For all of them together represent the worker's real reward.

The proposals which I am making today reflect this consideration.

I propose increases in Federal compensation of \$485 million per year.

I am asking the Congress to enact legislation which will provide an average increase for Federal civilian employees amounting to 3.2 percent of total compensation.

On the average, direct salary increases will amount to 2.85 percent. The other increases are for fringe benefits to assist the Government employee in providing for his own economic security.

In considering these proposals, I urge careful study of the supporting data and background information contained in the two reports transmitted with this message:

1. The report of the Cabinet Committee on Federal Staff Retirement Systems, prepared in response to my request of February 1, 1965, for a review of Federal retirement policies and benefits.

2. The annual report to the President of the Director of the Bureau of the Budget and the Chairman of the Civil Service Commission on the comparison between Federal civilian pay levels and those in private enterprise—as required by law.

I also urge the Congress to take into account two other considerations of utmost importance to the Federal employee—and all wage earners—and the Nation as a whole:

The wage-price guideposts which are key weapons in our defense against inflation, and

Sound and responsible Federal fiscal policy.

Both of these considerations weighed heavily in my mind as I studied various possible recommendations to make to the Congress this year. For nothing will destroy the progress of the Federal employee in his efforts to achieve comparability more effectively than the erosion of inflation.

PAY

I recommend to the Congress the enactment of a pay raise for Federal employees—effective January 1, 1967—ranging from 1 percent to 4½ percent.

With these increases, nearly 1 million of the 1.8 million employees affected will achieve pay comparability with private enterprise. These employees include about 88 percent of all postal workers and the more than 470,000 Classification Act employees in grades GS-1 through GS-5.

The smallest increase of approximately 1 percent will go to the lowest of the two grades of the classification system which are already above comparability. The modestly higher increases will go to the relatively few upper grades where the current comparability difference is larger and where, accordingly, our recruiting difficulties are greatest.

RETIREMENT

I shall not detail in this message all of the changes recommended by the Cabinet Committee on Federal Staff Retirement Systems. The report speaks for itself clearly and succinctly. I endorse it.

I call particular attention to three proposals which I believe to be most urgent. These are:

1. Those who reach age 55 with 30 years of service, should be allowed to retire without reduction in annuity. The Government should also have the option to retire involuntarily, at age 55, employees in grades GS-13 and above who have 30 or more years of service.

2. We should guarantee that retirement, disability, and survivor benefits are at least equal to benefits payable under the old-age and survivors disability insurance program of the social security system.

3. We should provide for the transfer to the social security system of service credits of employees who die, become disabled, or leave Federal employment before becoming eligible for Federal retirement systems benefits.

I recommended that these three proposals, like the basic pay increases, be made effective January 1, 1967.

I also recommend:

The enactment into law of a clear statement of retirement policy, as set forth in detail on pages 10 and 11 of the Cabinet Committee's report.

Adjustments between the civil service and the Foreign Service retirement systems.

The ultimate costs of all of the proposed changes in the retirement systems are set forth in tabular form on pages 21 and 22 of the Committee's report. This report also contains a sound financing plan. It is essential that we place our retirement system on a sound basis of financing as soon as possible.

I recommend that financing provisions be enacted as a part of the retirement legislation, including a 0.5-percent increase in contributions of both agencies and employees, effective January 1, 1967.

The report of the Cabinet Committee does not deal with changes in the military retirement system. Although the Committee reviewed important aspects of military retirement, it agreed with the Secretary of Defense that recommendations for fundamental changes should wait completion of a broad management study now underway in the Department of Defense.

The retirement report and the recommendations for legislation presented by it are major steps forward in our continuing efforts to improve the compensation system for Federal employees. In my judgment, they are equal in importance to the 1962 Federal Salary Reform Act.

OTHER BENEFITS

I recommend a phased 2-year increase in the Government's contribution to our civilian health benefits program.

The first increase should be effective on January 1, 1967; the second on January 1, 1968. These increases would restore the ratio of costs to the Government and costs to the employee established by the original Health Benefits Act of 1959.

The effective date of other important adjustments in our retirement system should be deferred for at least another year. The most important of these are to:

1. Extend medicare to Federal civilian employees.
2. Continue benefits until age 22 for those surviving children of deceased Federal employees who are continuing their education.
3. Compute benefits on the basis of a guaranteed disability minimum to widows of employees who die after retirement for disability.
4. Continue benefits for a surviving widow if she remarries after age 60.

NEED FOR NEW KNOWLEDGE

If we are to continue to modernize our policy of total compensation, we need better information than is now available. We must examine all of the *fringe benefits* in our compensation system. These include

leave, holiday pay, special pay differentials, unemployment insurance, Federal Employees Compensation Act benefits for duty-related accidents and illness, health benefits, life insurance, and counterpart benefits prevailing elsewhere in our economy.

I am recommending that the Congress appropriate funds for collection and evaluation of information on non-Federal fringe benefits in the budget of the Department of Labor for 1967.

CONCLUSION

The measures I am proposing meet the test of fairness to our employees. They also meet the test of economic responsibility.

For the past many months, the Government has appealed to labor and industry alike to hold price and wage increases within the guidelines established by the Council of Economic Advisers.

If our Government is to exercise continued leadership in the fight for price stability, then we must continue to practice what we preach. The Government has the added responsibility of not contributing to inflation by its own actions.

With 5 years of unprecedented economic expansion, our industry is now operating near the peak of its capacity. Added to this, we now have the obligation to support our fighting men in Vietnam and our commitment to freedom there.

This administration has already proved that our Nation does not have to live with depression or recession. Now we must prove that we can remain both strong and prosperous without endangering our economic stability.

Government employees have a direct stake in this effort. For none is more harmed by inflation—and harmed more quickly—than the wage earner and the salaried employee. It is of small value to him if the extra dollar he earns buys less and less with every passing week.

We are the wealthiest nation in history. We can afford whatever is necessary for both our welfare at home and our common defense abroad. But we can do this only by the exercise of fiscal prudence and economic responsibility during times when special demands are being made on our economy by the military needs of Vietnam.

I am certain that both Government employees and the leaders of their organizations will recognize that restraint serves both their cause and the national interest. They will recognize that these proposals meet three essential requirements:

First, that taken together, pay, retirement, and health benefits amount to an increase of the maximum total compensation increase within the wage-price guidelines.

Second, that the major increases will go to those Federal workers whose compensation is least comparable with private enterprise.

And third, that these proposals move the entire pay scale toward full comparability in an orderly manner.

The annual cost of these proposals will amount to \$485 million. If they are made effective on January 1, 1967—which I urgently recommend—the cost for the next fiscal year will be \$240 million. These costs are fully provided for in the budget which I submitted to the Congress in January.

The Federal Government is the largest employer in the Nation. The largest employer has an undeniable responsibility to lead, and not merely to follow, in instituting and adhering to model employment practices.

A model employer can demand excellence in performance. A model employer can demand continuing awareness of the need for greater productivity, more imaginative conduct of Government programs, and substantial cost reduction. We have made those demands.

Federal officers and employees at all levels have responded with enthusiasm and skill. If they had not been determined to improve the efficiency and economy of Government operations, budget costs in both 1966 and 1967 would be some \$3 billion higher than they are.

By the close of this fiscal year, the total compensation for our 2½ million Federal civilian employees will be \$20.4 billion a year. With expenditures of such magnitude, the President, the Congress, and Federal employees themselves, cannot fail to give the most careful consideration to every adjustment in pay, retirement, and health benefits. Each proposed adjustment must not only be merited, it should also be consistent with the principles of sound government.

LYNDON B. JOHNSON.

THE WHITE HOUSE, *March 7, 1966.*

LETTER OF SUBMITTAL

MARCH 3, 1966.

Memorandum for the President.

Subject: Joint annual report on the Federal statutory salary systems.

Pursuant to the Federal Salary Reform Act of 1962 and Executive Order 11073, we are submitting the joint annual report of the Director of the Bureau of the Budget and the Chairman of the Civil Service Commission on Federal statutory salary systems.

The report compares the present Federal statutory salary rates with average salary rates paid for the same levels of work in private enterprise as reported in November 1965 in the National Survey of Professional, Administrative, Technical, and Clerical Pay, conducted by the Bureau of Labor Statistics. It recommends attainment of such degree of comparability as is possible within the wage-price guideposts.

CHARLES L. SCHULTZE,
Director, Bureau of the Budget,

JOHN W. MACY, Jr.,
Chairman, Civil Service Commission.

Attachment.

FEDERAL STATUTORY SALARY SYSTEMS

JOINT ANNUAL REPORT

OF

Director, Bureau
of the Budget

Chairman, Civil Service
Commission

MARCH 1966

FEDERAL STATUTORY SALARY SYSTEMS

Federal-Private Enterprise Salary Comparisons—Joint Annual Report, March 3, 1966

In accordance with section 503 of the Federal Salary Reform Act and with Executive Order 11073 of January 2, 1963, we submit this joint annual report of the Chairman of the Civil Service Commission and the Director of the Bureau of the Budget.

The report:

1. Compares Federal statutory salary rates with the private enterprise salary rates for the same work levels reported in November 1965 by the Bureau of Labor Statistics in its National Survey of Professional, Administrative, Technical, and Clerical Pay, February–March 1965;
2. Shows the new Federal salary schedules needed for comparability with 1965 private enterprise rates;
3. Reports our communications with national Federal employee organizations on the comparisons; and
4. Recommends such adjustments in compensation as appear to be appropriate at this time.

The four statutory salary systems with which this report is concerned are those of the Classification Act, the postal field service, the Foreign Service, and that covering physicians, dentists, and nurses in the Department of Medicine and Surgery of the Veterans' Administration.

I. COMPARISONS

The 3.6-percent adjustment in pay authorized as of October 1, 1965, produced statutory salary schedules which left the various grades in uneven relationship to private enterprise rates. The adjustment pushed clerical grades above comparability with the 1964 rates reported by the Bureau of Labor Statistics by amounts which varied from more than 4 percent at GS-1 to less than 1 percent at GS-5. At GS-6 and higher grades the 1965 adjustment permitted Federal salary rates to trail the 1964 private enterprise rates. At several of the highest grades the Federal rates are approximately comparable with 1962 private enterprise rates.

The private enterprise salary levels reported by BLS in November 1965 are compared, in table 1 in appendix A, with those reported in 1964. The 1965 survey, for the first time, covered nonmetropolitan as well as metropolitan United States. The 1964 and previous surveys covered only standard metropolitan statistical areas. Consequently, the differences shown between the 1965 and 1964 rates cannot be used as a measure of the annual increase in private enterprise salaries.

In its 1965 report, the BLS calls attention to the fact that professional and administrative salary rates in private enterprise have

been rising more rapidly than clerical rates and summarizes the trend over the past 4 years as follows:

<i>Work levels</i>	<i>Private enterprise increases, 1961-1966 (in percent)</i>
Clerical.....	10.6
Lower professional and administrative.....	13.7
Higher professional and administrative.....	15.2

So sustained a trend has gradually changed the pattern of the private enterprise rates to which the Federal comparability payline is fitted; and the shape of payline which we have recommended in past years does not adequately reflect the change.

The payline is the instrument for reconciling the two principles established by the Federal Salary Reform Act. One principle calls for comparability with private enterprise rates while the other prescribes equal pay for equal work and pay distinctions in keeping with work distinctions. A payline which runs directly through private enterprise averages for the various grades does not provide adequate pay distinctions; and a line which provides ideal pay distinctions runs too far below some private enterprise grade averages and too far above others. The line which we have used in past years, and the new shape adopted this year, are compromises providing relatively reasonable pay distinctions between grades and running relatively close to private enterprise grade averages. The new shape of payline runs closer to private enterprise averages and provides somewhat better pay distinctions. Table 2 of appendix A shows the new payline and sets forth the increases which the line would provide over current statutory salary rates.

Salary schedules based upon the new payline for the four statutory systems are shown in Appendix B.

II. CHANGES IN THE SURVEY

Extension of the survey to nonmetropolitan areas was in accord with a recommendation of the Surveys & Research Corp. after their review, 2 years ago, of the survey used for Federal comparability purposes. Also in accord with that corporation's recommendation is the extension of the current 1966 BLS survey to establishments of smaller size.

The corporation's review was made concurrently with another review by a panel of salary administrators from large private firms. One of the panel's recommendations was inclusion of certain additional occupations in the survey, and in accord therewith the 1966 survey is collecting pay data on the additional jobs of secretary, freight rate clerk, and buyer. If the survey is successful relative to the new jobs, it should be possible hereafter to utilize the private enterprise data for jobs equivalent to GS-5 in computing the Federal comparability payline.

Although the survey has produced excellent data on several professional, administrative, and technical jobs at the private enterprise equivalent of GS-5, the data have not been used this year nor in past years in comparability computations. Determination against use of the data is based upon the fact that more than 70 percent of GS-5 employees are engaged in clerical work, yet no data have been available to date on private enterprise rates for clerical work at this level. Until such data are available, it does not seem possible to accept the findings at GS-5 as being sufficiently representative of private rates

for the work level. Repeated prior attempts to survey pay for GS-5 clerical jobs have failed, but successful survey of the newly added jobs should satisfy the criterion of representativeness and permit use of the data in computing Federal comparability salaries.

The corporation and the panel made several other recommendations on the comparability process which have been accepted, and the 1966 survey incorporates all of the adopted recommendations.

III. OTHER FACTORS

Comparability of salary rates should be considered in relation to other pertinent factors. One of the most important of such factors is the state of the economy and the intent of the wage-price guideposts. It is especially important at this time that Federal pay increases should not become an inflationary force by exceeding the guideposts.

Furthermore, although salary is the major part, it is not the whole of compensation, and salary comparisons should be reviewed against the background of total compensation. The total compensation concept is necessary to any application of wage-price guideposts. It is also necessary to insure true equity for the Federal employee with his work equals throughout the economy.

A BLS study of compensation supplemental to salary in 1963 showed that private enterprise expenditures for supplemental compensation, viewed as a percentage of straight-time payroll, were approximately equal to Federal expenditures for such purposes. Funds were requested by the administration for a more up-to-date study in fiscal year 1966, but were denied by the Congress. Since 1963 there has been some increase in Federal supplemental compensation, and an additional increase will be sought coincident with the salary adjustment to be recommended. However, there is considerable evidence which suggests that private enterprise expenditures for fringe benefits may be increasing at an even faster pace. New OASDI contributions alone represent a material increase in private enterprise expenditures. A BLS study of supplemental compensation in 1964 for manufacturing production workers shows widespread improvements in life insurance, health benefits, sickness and accident benefits, as well as substantial liberalization in company retirement plan provisions.

All the evidence indicates the importance of up-to-date information on supplemental compensation, and we have accordingly again requested funds for a BLS survey in fiscal year 1967.

We believe that it is also pertinent to review private enterprise comparability rates in relation to State and local government salary rates. Unfortunately, there are not yet available valid and reliable statistical data on State and local rates. It appears, however, from the 1965 report of the Public Personnel Association that the rates paid by most of the larger State and local jurisdictions generally may approximate and sometimes surpass those paid by the Federal Government. Since State and local government employees now make up more than 10 percent of nonagricultural employment, and their number is still growing, we believe that collection of salary data should be authorized.

Career comparability salary rates are affected by still another factor, which is the relationship of top career rates to executive, congressional, and judiciary rates. Although GS-16, GS-17, and GS-18 rates trail further behind the comparability pay line rates than do rates at any

other grades, they cannot now be appropriately adjusted without exceeding the current rates of higher executive levels. Pay movements throughout the economy have demonstrated that this is a continuing problem. The problem can best be met by statutory creation of new machinery for rationalized movement of executive, congressional, and judiciary salaries in relation to the needed movement in the highest career salaries. Last year the administration asked for creation of such machinery, but no provisions were enacted. We recommend that at the appropriate time the administration should renew its request for statutory creation of such machinery. In the meantime, it might be desirable to assemble another Presidential panel to review the problem.

Relating the executive level salary adjustments to the adjustments required in the highest career grades is not an unusual concept. Available indicators show somewhat parallel movement in the private economy. The American Management Association Top Management Report for 1965, for instance, showed an increase for the past year which compares closely with the magnitude of increases in the higher career grades covered by the BLS survey.

IV. COMMUNICATIONS WITH NATIONAL EMPLOYEE ORGANIZATIONS

Discussions have been held with several employee organizations on pay matters generally, and on issues relative to the comparability principle. In addition, the specific 1965 comparability findings contained in appendix A of this report have been sent to over 40 Federal employee organizations. To date none of them has expressed any views in writing. Any comment which may be offered by the employee groups will be forwarded to you as received.

V. RECOMMENDATION

We recommend that any increases in Federal compensation which you may decide to propose to the Congress for enactment this year (1) not exceed the wage-price guidepost figure of 3.2 percent; and (2) be in a package consisting of salary increases and improvements in fringe benefits, including Federal retirement.

VI. VIEWS OF AGENCY HEADS

The Secretary of State, the Postmaster General, and the Administrator of Veterans' Affairs concur in this report as it affects the special statutory salary systems covering employees in their agencies.

VII. COSTS

The annual cost of attaining full comparability with 1965 private enterprise rates, using the new payline, would far exceed any amount permissible under the wage-price guideposts. Nevertheless, we have estimated the costs as follows:

	<i>Millions</i>
Classification Act.....	\$618.3
Postal field service.....	125.0
Veterans' Administration, Department of Medicine and Surgery.....	21.2
Foreign Service.....	21.0
Total salary costs.....	785.5
Plus retirement and insurance.....	51.8
Total.....	837.3

We estimate that an increase of 3.2 percent in total compensation would involve a full-year cost of about \$485 million. The distribution of this amount between pay and other benefits will depend upon the items included in any package proposal.

APPENDIX A

TABLE 1.—Comparison—1964 and 1965 private enterprise rates

Grade	Occupation	1964	1965	Percent difference
GS-1	File clerk I	\$3,106	\$3,176	
	Office boys or girls	3,369	3,472	
	Average	3,238	3,324	2.7
GS-2	File clerk II	3,530	3,599	
	Keypunch operator I	3,918	3,947	
	Switchboard operator I	4,282	4,140	
	Tabulating machine operator I	4,031	4,105	
	Typist I	3,569	3,646	
	Average	3,826	3,887	1.6
GS-3	Engineering technician I	4,872	4,932	
	Draftsman-tracer	4,329	4,345	
	Accounting clerk I	4,169	4,235	
	File clerk III	4,419	4,512	
	Keypunch operator II	4,513	4,590	
	Stenographer, general	4,269	4,338	
	Switchboard operator II	4,746	4,774	
	Tabulating machine operator II	4,937	5,054	
	Typist II	4,248	4,336	
	Average	4,497	4,568	1.6
GS-4	Engineering technician II	5,820	5,892	
	Draftsman I	5,395	5,424	
	Accounting clerk II	5,530	5,589	
	Stenographer, senior	4,842	4,946	
	Tabulating machine operator III	5,951	6,097	
	Average	5,508	5,590	1.5
GS-5	Accountant I	6,240	6,312	
	Auditor I	5,832	6,204	
	Job analyst I	6,576	6,636	
	Chemist I	6,456	6,612	
	Engineer I	7,344	7,512	
	Engineering technician III	6,672	6,828	
	Draftsman II	(1)	6,875	
	Average	2 6,520	2 6,711	2.9
GS-7	Accountant II	6,840	7,044	
	Auditor II	7,188	7,440	
	Attorney I	7,248	7,368	
	Job analyst II	7,452	7,668	
	Chemist II	7,320	7,584	
	Engineer II	8,004	8,292	
	Engineering technician IV	7,512	7,680	
	Draftsman III	(1)	8,038	
	Average	7,366	7,639	3.7
GS-9	Accountant III	7,908	8,124	
	Auditor III	8,520	8,748	
	Attorney II	8,532	8,940	
	Manager, office services I	7,500	7,752	
	Job Analyst III	8,544	8,892	
	Chemist III	8,604	8,808	
	Engineer III	9,204	9,468	
	Engineering technician V	8,556	8,676	
	Average	8,421	8,676	3.0
GS-10	Manager, office services II	2 9,240	2 9,624	2 4.6

See footnotes at end of table, p. 8.

TABLE 1.—Comparison—1964 and 1965 private enterprise rates—Continued

Grade	Occupation	1964	1965	Percent difference
GS-11....	Accountant IV.....	\$9,504	\$9,792	-----
	Auditor IV.....	10,284	10,728	-----
	Chief accountant I.....	10,296	10,740	-----
	Attorney III.....	10,464	10,512	-----
	Manager, office services III.....	10,992	11,412	-----
	Job analyst IV.....	10,104	10,668	-----
	Director of personnel I.....	9,660	9,576	-----
	Chemist IV.....	10,632	10,980	-----
	Engineer IV.....	11,016	11,376	-----
	Average.....	10,336	10,643	3.0
GS-12....	Accountant V.....	11,568	11,940	-----
	Chief accountant II.....	12,576	12,588	-----
	Attorney IV.....	12,816	13,644	-----
	Manager, office services IV.....	12,948	13,824	-----
	Director of personnel II.....	11,160	11,352	-----
	Chemist V.....	12,744	13,068	-----
	Engineer V.....	12,924	13,272	-----
	Average.....	12,391	12,813	3.4
GS-13....	Chief accountant III.....	14,124	14,604	-----
	Attorney V.....	16,032	16,500	-----
	Director of personnel III.....	13,836	14,520	-----
	Chemist VI.....	14,748	15,168	-----
	Engineer VI.....	14,820	15,336	-----
	Average.....	14,724	15,226	3.4
GS-14....	Chief accountant IV.....	15,498	17,028	-----
	Attorney VI.....	18,420	20,040	-----
	Director of personnel IV.....	16,512	16,956	-----
	Chemist VII.....	17,328	17,928	-----
	Engineer VII.....	17,652	18,012	-----
	Average.....	17,172	17,993	4.8
GS-15....	Attorney VII.....	24,288	24,804	-----
	Chemist VIII.....	21,084	22,212	-----
	Engineer VIII.....	20,484	21,108	-----
	Average.....	21,952	22,708	3.4

¹ Not in 1964 survey.² Not used in developing comparability pay line.

TABLE 2.—Comparison of current Classification Act rates with 1965 comparability payline rates

Grade	1965 private enterprise averages	Pay line		Current 4th rates	Increases	
		Differentials (percent)	Rates		Dollars	Percent
GS-1.....	\$3,324	-----	\$3,595	\$3,864	(¹)	(¹)
GS-2.....	3,887	-----	4,085	4,201	(¹)	(¹)
GS-3.....	4,688	28.4	4,615	4,569	\$46	1.0
GS-4.....	5,590	-----	5,195	5,109	86	1.7
GS-5.....	-----	26.3	5,830	5,694	136	2.4
GS-6.....	-----	-----	6,510	6,278	232	3.7
GS-7.....	7,639	24.4	7,255	6,890	365	5.3
GS-8.....	-----	-----	8,045	7,553	492	6.5
GS-9.....	8,676	22.7	8,900	8,241	659	8.0
GS-10.....	-----	-----	9,800	9,024	776	8.6
GS-11.....	10,463	21.2	10,785	9,879	906	9.2
GS-12.....	12,813	19.9	12,935	11,723	1,212	10.3
GS-13.....	15,242	18.8	15,365	13,815	1,505	11.2
GS-14.....	17,993	17.9	18,115	16,204	1,911	11.8
GS-15.....	22,708	17.2	21,230	18,825	2,405	12.8
GS-16.....	-----	16.7	24,775	21,653	3,122	14.4
GS-17.....	-----	16.4	28,835	24,548	4,287	17.5
GS-18.....	-----	16.3	² 30,490	² 25,382	5,108	20.1

¹ Current rates in excess of comparability rates.² Single (entry) rate.

FEDERAL STATUTORY SALARY SYSTEMS

9

APPENDIX B

1965 comparability pay schedule—Classification Act

FSS	Pay line									
	1	2	3	4	5	6	7	8	9	10
GS-1.....	\$3,265	\$3,375	\$3,485	\$3,595	\$3,705	\$3,815	\$3,925	\$4,035	\$4,145	\$4,255
GS-2.....	3,710	3,835	3,960	4,085	4,210	4,335	4,460	4,585	4,710	4,835
GS-3.....	4,195	4,335	4,475	4,615	4,755	4,895	5,035	5,175	5,315	5,455
GS-4.....	4,730	4,885	5,040	5,195	5,350	5,505	5,660	5,815	5,970	6,125
GS-5.....	5,305	5,480	5,655	5,830	6,005	6,180	6,355	6,530	6,705	6,880
GS-6.....	5,925	6,120	6,315	6,510	6,705	6,900	7,095	7,290	7,485	7,680
GS-7.....	6,595	6,815	7,035	7,255	7,475	7,695	7,915	8,135	8,355	8,575
GS-8.....	7,310	7,555	7,800	8,045	8,290	8,535	8,780	9,025	9,270	9,515
GS-9.....	8,090	8,360	8,630	8,900	9,170	9,440	9,710	9,980	10,250	10,520
GS-10.....	8,915	9,210	9,505	9,800	10,095	10,390	10,685	10,980	11,275	11,570
GS-11.....	9,810	10,135	10,460	10,785	11,110	11,435	11,760	12,085	12,410	12,735
GS-12.....	11,765	12,155	12,545	12,935	13,325	13,715	14,105	14,495	14,885	15,275
GS-13.....	13,970	14,435	14,900	15,365	15,830	16,295	16,760	17,225	17,690	18,155
GS-14.....	16,465	17,015	17,565	18,115	18,665	19,215	19,765	20,315	20,865	21,415
GS-15.....	19,295	19,940	20,585	21,230	21,875	22,520	23,165	23,810	24,455	25,100
GS-16.....	22,525	23,275	24,025	24,775	25,525	26,275	27,025	27,775	28,525	-----
GS-17.....	26,210	27,085	27,960	28,835	29,710	-----	-----	-----	-----	-----
GS-18.....	30,490	-----	-----	-----	-----	-----	-----	-----	-----	-----

1965 comparability pay schedule—Postal Field Service

PFS	Per annum rates and steps											
	1	2	3	4	5	6	7	8	9	10	11	12
1.....	\$4,170	\$4,310	\$4,450	\$4,590	\$4,730	\$4,870	\$5,010	\$5,150	\$5,290	\$5,430	\$5,570	\$5,710
2.....	4,520	4,670	4,820	4,970	5,120	5,270	5,420	5,570	5,720	5,870	6,020	6,170
3.....	4,890	5,055	5,220	5,385	5,550	5,715	5,880	6,045	6,210	6,375	6,540	6,705
4.....	5,305	5,480	5,655	5,830	6,005	6,180	6,355	6,530	6,705	6,880	7,055	7,230
5.....	5,745	5,935	6,125	6,315	6,505	6,695	6,885	7,075	7,265	7,455	7,645	7,835
6.....	6,225	6,430	6,635	6,840	7,045	7,250	7,455	7,660	7,865	8,070	8,275	8,480
7.....	6,730	6,955	7,180	7,405	7,630	7,855	8,080	8,305	8,530	8,755	8,980	-----
8.....	7,285	7,530	7,775	8,020	8,265	8,510	8,755	9,000	9,245	9,490	-----	-----
9.....	7,890	8,155	8,420	8,685	8,950	9,215	9,480	9,745	10,010	10,275	-----	-----
10.....	8,500	8,785	9,070	9,355	9,640	9,925	10,210	10,495	10,780	11,065	-----	-----
11.....	9,110	9,405	9,700	10,000	10,300	10,600	10,900	11,200	11,500	11,800	-----	-----
12.....	9,720	10,025	10,330	10,635	10,940	11,245	11,550	11,855	12,160	12,465	-----	-----
13.....	10,330	10,645	10,960	11,275	11,590	11,905	12,220	12,535	12,850	13,165	-----	-----
14.....	10,940	11,265	11,590	11,915	12,240	12,565	12,890	13,215	13,540	13,865	-----	-----
15.....	11,550	11,885	12,210	12,535	12,860	13,185	13,510	13,835	14,160	14,485	-----	-----
16.....	12,160	12,495	12,820	13,145	13,470	13,795	14,120	14,445	14,770	15,095	-----	-----
17.....	12,770	13,105	13,430	13,755	14,080	14,405	14,730	15,055	15,380	15,705	-----	-----
18.....	13,380	13,715	14,040	14,365	14,690	15,015	15,340	15,665	15,990	16,315	-----	-----
19.....	13,990	14,325	14,650	14,975	15,300	15,625	15,950	16,275	16,600	16,925	-----	-----
20.....	14,600	14,935	15,260	15,585	15,910	16,235	16,560	16,885	17,210	17,535	-----	-----

1965 comparability pay schedule

FOREIGN SERVICE OFFICERS

FSO	Pay line						
	1	2	3	4	5	6	7
1.....	\$28,490	\$29,440	\$30,490	-----	-----	-----	-----
2.....	22,225	22,965	23,705	\$24,445	\$25,185	\$25,925	\$26,665
3.....	17,510	18,095	18,680	19,265	19,850	20,435	21,020
4.....	13,970	14,435	14,900	15,365	15,830	16,295	16,760
5.....	11,295	11,670	12,045	12,420	12,795	13,170	13,545
6.....	9,265	9,575	9,885	10,195	10,505	10,815	11,125
7.....	7,735	7,995	8,255	8,515	8,775	9,035	9,295
8.....	6,595	6,815	7,035	7,255	7,475	7,695	7,915

FEDERAL STATUTORY SALARY SYSTEMS

1965 comparability pay schedule—Continued

FOREIGN SERVICE STAFF

FSS	Pay line									
	1	2	3	4	5	6	7	8	9	10
1.....	\$17,510	\$18,095	\$18,680	\$19,265	\$19,850	\$20,435	\$21,020	\$21,605	\$22,190	\$22,775
2.....	13,970	14,435	14,900	15,365	15,830	16,295	16,760	17,225	17,690	18,155
3.....	11,295	11,670	12,045	12,420	12,795	13,170	13,545	13,920	14,295	14,670
4.....	9,265	9,575	9,885	10,195	10,505	10,815	11,125	11,435	11,745	12,055
5.....	8,290	8,565	8,840	9,115	9,390	9,665	9,940	10,215	10,490	10,765
6.....	7,410	7,655	7,900	8,145	8,390	8,635	8,880	9,125	9,370	9,615
7.....	6,620	6,840	7,060	7,280	7,500	7,720	7,940	8,160	8,380	8,600
8.....	5,920	6,115	6,310	6,505	6,700	6,895	7,090	7,285	7,480	7,675
9.....	5,290	5,465	5,640	5,815	5,990	6,165	6,340	6,515	6,690	6,865
10.....	4,730	4,885	5,040	5,195	5,350	5,505	5,660	5,815	5,970	6,125

1965 comparability pay schedule—Veterans' Administration, Department of Medicine and Surgery

	Minimum	Maximum
Assistant Chief Medical Director.....	\$30,490	-----
Medical Director.....	26,210	\$29,710

PHYSICIANS AND DENTISTS

Director grade.....	\$22,525	\$28,525
Executive grade.....	20,865	27,120
Chief grade.....	19,295	25,100
Senior grade.....	16,465	21,415
Intermediate grade.....	13,970	18,155
Full grade.....	11,765	15,275
Associate grade.....	9,810	12,735

NURSES

Director of Nursing.....	\$19,295	\$25,100
Assistant Director grade.....	16,465	21,415
Chief grade.....	13,970	18,155
Senior grade.....	11,765	15,275
Intermediate grade.....	9,810	12,735
Full grade.....	8,090	10,520
Associate grade.....	6,960	9,030
Junior grade.....	5,925	7,680

CABINET COMMITTEE ON FEDERAL STAFF RETIREMENT SYSTEMS,

Washington, D.C., February 15, 1966.

THE PRESIDENT,
The White House,
Washington, D.C.

DEAR MR. PRESIDENT: Your memorandum of February 1, 1965, asked us to review the structure of the Federal Government's staff retirement systems, civilian and military, and to recommend changes necessary to make those systems fully effective and more equitable.

In order to provide a broad perspective for our work, we have:

Reviewed what industry and other public jurisdictions are doing about retirement.

Sought the views of top civilian and military managers in Government.

Analyzed a large volume of correspondence addressed to the Committee.

Held public hearings at which 26 employee organizations and other groups presented criticisms and recommendations.

The information so obtained has helped to sharpen our findings and to shape our conclusions and recommendations.

CIVILIAN STAFF RETIREMENT SYSTEMS

We have concluded that, despite certain inconsistencies and shortcomings, Government's civilian staff retirement systems are liberal and generally fair. Some existing differences between the civil service and the Foreign Service systems are justifiable and even necessary. Where differences do not appear to be justified, we recommend their elimination. Benefit levels, conditions of eligibility for retirement, and relationship between retirement benefits and current pay levels need only a few major changes at this time.

These are our major recommendations for improvement of the civilian retirement systems:

1. *Comparability and cost control.*—The principle of comparability should be applied to total compensation (pay plus fringe benefits) of civilian personnel, and an equitable relationship between total compensation of military and civilian personnel should be maintained. Expenditures for fringe benefits should be identified and controlled, and procedures for gathering data and comparing costs should be improved.

2. *Postretirement adjustment of benefits.*—Government should maintain the purchasing power of annuities and retired pay of its retirees. The present method of making adjustments based on increases in the Consumer Price Index serves this purpose well. It should be retained, and the same adjustment formula should be applied by all systems, including that for the uniformed services.

3. *Relationship to social security.*—

(a) Transfer of credits: When a civil service or Foreign Service employee (including an employee who separates from such service in the future) or his family are ineligible for staff retirement benefits at the time he dies, becomes disabled, or reaches retirement age, his credits should be transferred to social security, and his Federal employment should be treated as if it had been performed under social security.

(b) Guaranteed minimum annuity: Civil service and Foreign Service employees, and their survivors, who become eligible for staff retirement benefits should receive from the retirement system (or from the retirement system and social security together if a social security benefit is payable on the basis of other work) amounts at least equal to the social security benefits that would be payable if the social security benefit computation formula had been applicable to the Federal service.

(c) Medicare: All future civilian appointees to the Federal service, and all present employees who desire such coverage, should be covered under the social security health insurance program, and should be provided optional complementary coverage with Government sharing the cost.

4. *Civil service age-service retirement requirements.*—

(a) Age 65 should be established as the normal retirement age, but retention on a year-to-year basis should be permitted up to age 70; voluntary retirement on full annuity should be permitted beginning at age 55 with 30 years of service, at age 60 with 20 years, and (as at present) at age 62 with 5 years; and retirement should be mandatory at age 70 for employees with 5 years of service.

(b) The high-5 average salary should be determined (except in the case of elected officials) on the basis of salaries earned before reaching age 65.

(c) Preferential early retirement provisions should remain confined to those occupations requiring performance of hazardous law-enforcement duties.

(d) Persons appointed after age 65 should be covered by social security rather than the staff retirement system, and existing authority to reemploy annuitants at any age should be retained, with provision for short-term reemployment without sacrifice in pay.

5. *Two-way option at GS-13 and above.*—Agencies should be authorized to retire, at management's discretion, any civil service employee at GS-13 (or equivalent) and above who has reached age 55 and has 30 years of service, an option already available to employees but not to management.

6. *Financing and funding.*—

(a) Civil service and Foreign Service employees and their employing agencies should share equally the normal costs of retirement, including normal costs of future liberalizations, and their contribution rates should be raised as required to cover these costs. Government should meet remaining costs through special appropriations and should take action to peg the trust fund at a predetermined level sufficient to assure prompt payment of all annuities

as they become due in the future. Suggested financing methods are outlined in detail in the recommendation.

(b) The civil service and Foreign Service retirement funds should be merged, but the systems themselves should remain independent.

MILITARY STAFF RETIREMENT SYSTEM

We have not dealt extensively with the retirement system for the uniformed services. That system is being studied in depth as part of a broad force management study being conducted by the Department of Defense. We have, therefore, confined our recommendations regarding military retirement to matters which would not compromise or prejudice the conclusions of the Defense Department.

FEDERAL EMPLOYEES' COMPENSATION ACT

The Committee staff prepared an analysis of relationships between benefits of the retirement systems and those available under the Federal Employees' Compensation Act. The Committee presents no substantive recommendation at this time on steps which might be taken to bring about better integration or coordination of the two benefit structures. In the present day employment situation there is concern for the replacement or maintenance of income of all disabled employees and the survivors of deceased employees, not solely those whose disabilities or deaths are job connected. We believe that the different concepts, administrative procedures, and organizational arrangements which have developed under 50 years of operation of the Federal employees' compensation system require more extensive study and examination of alternative proposals for change. Accordingly, we recommend a thorough and separate restudy and report by the Department of Labor, the Civil Service Commission, and the Bureau of the Budget, with the participation of other interested agencies. They are prepared to undertake this work promptly.

REPORT OF THE COMMITTEE

Our report to you is attached. We recommend that it be transmitted to the Congress in order to provide a line of departure for collaboration between the executive branch and the Congress in improving retirement laws.

The first section of the report is designed as a review of retirement objectives, issues, concepts, and of our conclusions about the Federal systems. It presents (on pp. 10 and 11) a proposed statement of policy to shape future development and improvement of the Federal staff retirement systems. We believe that such a statement is needed, and should apply to all Federal retirement systems. Up to the present time the retirement systems have evolved independently of each other and of the social security system, without coherent overall planning or clear guiding principles.

The second section of the report contains our recommendations and discusses them briefly. A spreadsheet summarizing estimated costs of the various proposals is on pages 21 and 22 of the report.

Not forwarded herewith, because of its length, is a series of more detailed analyses, background papers, and tables of statistical data. These were prepared or compiled by the staff in the course of the study. The Committee has not specifically endorsed or approved this additional material. We recommend, nevertheless, that it be separately transmitted to the Congress as an annex to the report. It contains much information which will be useful to the committees of the Congress, employee organizations, and others interested in such details.

LEGISLATION

Draft legislation is being prepared to carry out each recommendation of the report. With necessary language ready, it can be submitted to the Congress in accordance with such time schedule as you desire. In this way we shall be better prepared to respond promptly to the desires of congressional committees. There are now before the committees a large number of retirement bills on which action was deferred last year pending receipt of our report and your recommendations.

The Committee hopes that the work we have undertaken will prove to be useful and will provide the up-to-date guidelines requested in your initial instruc-

tion to us. We are grateful for this opportunity to make joint recommendations on Federal retirement policy and programs.

Respectfully,

CHARLES L. SCHULTZE,
Director, Bureau of the Budget,
Chairman of the Committee.

(For and in behalf of: Dean Rusk, Secretary of State; Robert S. McNamara, Secretary of Defense; Lawrence F. O'Brien, Postmaster General; W. Willard Wirtz, Secretary of Labor; John W. Gardner, Secretary of Health, Education, and Welfare; John W. Macy, Jr., Chairman of the Civil Service Commission).

REPORT TO THE PRESIDENT BY THE CABINET COMMITTEE ON FEDERAL STAFF RETIREMENT SYSTEMS, FEBRUARY 1966

CABINET COMMITTEE MEMBERS

Charles L. Schultze, Director, Bureau of the Budget (Chairman) (succeeded Kermit Gordon).
Dean Rusk, Secretary of State.
Robert S. McNamara, Secretary of Defense.
Lawrence F. O'Brien, Postmaster General (succeeded John A. Gronouski).
W. Willard Wirtz, Secretary of Labor.
John W. Gardner, Secretary of Health, Education, and Welfare (succeeded Anthony J. Celebrezze).
John W. Macy, Jr., Chairman, U.S. Civil Service Commission.

ALTERNATE MEMBERS

Elmer B. Staats, Bureau of the Budget.
William J. Crockett, Department of State.
Joseph Palmer II, Department of State.
Thomas D. Morris, Department of Defense (succeeded Norman S. Paul).
Frederick C. Belen, Post Office Department.
Richard J. Murphy, Post Office Department.
Leo R. Werts, Department of Labor.
Robert M. Ball, Department of Health, Education, and Welfare, Social Security Administration.
Nicholas J. Oganovic, U.S. Civil Service Commission (succeeded Warren B. Irons).

STAFF MEMBERS

David F. Lawton, U.S. Civil Service Commission, Executive Director.
Mrs. Elizabeth F. Messer, U.S. Civil Service Commission.
Robert W. Anderson, Department of Health, Education, and Welfare.
Gregory M. Barlous, Bureau of the Budget.
Bernard J. Beary, Post Office Department.
Sp4c. William E. Bless, U.S. Army.
Joseph G. Crunkilton, U.S. Civil Service Commission.
Jack A. DeS pio, U.S. Civil Service Commission.
Capt. Hugh M. Durham, U.S. Navy.
Sp4c. Leonard A. Flens, U.S. Army.
Mrs. Eileen C. Hall, U.S. Civil Service Commission.
Robert B. Hull, Jr., Department of State.
Irving J. Jacobs, Department of Health, Education, and Welfare.
Mrs. Lois G. Myers, U.S. Civil Service Commission.
Maj. Jack I. Posner, U.S. Air Force.
Miss Sara E. Spracher, U.S. Civil Service Commission.
Armin A. Surgies, Department of Health, Education, and Welfare.

ADVISERS

Roger W. Jones, Bureau of the Budget; Andrew E. Ruddock, U.S. Civil Service Commission; Brig. Gen. William W. Berg and Leon L. Wheelless, Department of Defense; Herbert Block, Post Office Department; Alvin M. David, Department of Health, Education, and Welfare.

SPECIAL CREDITS

Messrs. Harold Seidman, James F. C. Hyde, Jr., C. Spencer Platt, David H. McAfee, Michael S. March, and Thomas M. Stanners, Bureau of the Budget; Joseph B. Glenn, Department of Defense; Donald M. Landay, Philip Arnow, Thomas A. Tinsley, Peter Henle, and Mrs. Stella P. Manor, Department of Labor; Robert J. Myers, Francisco Bayo, and Gordon R. Trapnell, Department of Health, Education, and Welfare; Maurice S. Brown, John P. Jones, and Joseph Zisman, U.S. Civil Service Commission; Cedric W. Kroll, Department of the Treasury.

FEDERAL STAFF RETIREMENT SYSTEMS IN REVIEW

INTRODUCTION

Stated in the simplest and bluntest terms, the study of Federal retirement systems which produced this report was a direct result of conflicting management interests and employee demands. Mounting pressures of unmet needs on both sides triggered the study. Concessions on the part of both employees and management will have to be made if their divergent, though interdependent, interests are to be reconciled with proper regard for the public interest and if progress is to be resumed toward goals that will meet the needs of all concerned. That is one basic conclusion of this report.

The second basic conclusion is that, despite certain shortcomings, two of the three principal staff retirement systems—those for the civil service and the Foreign Service—need only a few major changes at this time and that complete evaluation of the third major system—that for the military service—should await completion of the intensive force management study now underway in the Department of Defense.

Compared with private employers and with State and local governments, Uncle Sam does well by his ex-employees, both civilian and uniformed. His retirement systems for them are already quite liberal in terms of benefit levels, conditions of eligibility for retirement, and relationship to current pay levels. A civilian employee who retires at normal retirement age after a full career receives an annuity of more than 55 percent of his average base salary for the 5 consecutive years that his earnings were highest, usually the last 5 years of his active career. A member of the uniformed services¹ who retires after 20 years of active duty will receive retired pay amounting to 50 percent of his basic pay (roughly equal to 35 percent of his preretirement income, including quarters and subsistence allowances and any job-related special pay to which he may have been entitled on active duty); since the average man in uniform retires in his early forties, he is expected to have a second career which will increase his total retirement income when he stops working. Both civilian and uniformed retirees of Government are assured of prompt and automatic benefit increases that keep pace with rising costs of living, an assurance not enjoyed by retirees of most other employers.

One would be tempted to conclude, therefore, that the Federal Government is doing as much as, or more than, it should be expected to do for its former workers. But careful examination of Government's principal retirement systems, which cover about 5 million individuals and their families, spotlights significant gaps in the protection they afford their members and needless inconsistencies of treatment among categories of workers. There are, in short, no grounds for complacency.

It would be relatively simple to prescribe the remedies if we ignored such practical considerations as traditions already established, entitlements already earned, costs already incurred, and additional costs accruing as the systems mature. But such considerations are hard realities, and they must be reckoned with. We have been constrained, therefore, to omit from this report certain recommendations that we would otherwise make; in several instances the recommendations we do make represent less-than-ideal solutions to significant problems, for the ideal solutions are plainly not attainable at this time. True coordination of the civil service and the Foreign Service systems with social security is one case in point. We have forgone that recommendation because coordination is still so strongly opposed by employee organizations that insisting on it now would only delay action on other, attainable improvements that are urgently needed. Improvements cost money. Every benefit increase, every other liberalization of the retirement systems, even every general pay increase bears a retirement price tag representing real costs far higher than is generally recognized; the figures on some of those tags effectively bar

¹ The uniformed services include the Army, Navy, Air Force, Marine Corps, Coast Guard, and the commissioned corps of the Public Health Service and of the Environmental Science Services Administration (which includes the Coast and Geodetic Survey), all of which are under substantially the same retirement system.

us as responsible public officials from supporting all of the changes that might otherwise be desirable.

Our recommendations (or failures to recommend) accommodate to such practical realities as these and thus fall short in some cases of the theoretically ideal. So, we believe, must the demands and the decisions of others concerned with retirement systems for the Federal work force.

BACKGROUND

Government's several staff retirement systems have evolved virtually independently of each other, as well as of the social security system (which most of them predated), and have developed without benefit of any coherent overall plan. In our national society and economy, however, broad programs of social insurance have been adopted for most of the Nation's work force; private pension and other employee benefit programs have been established and are flourishing; concern for special segments of the population—the aging, the disabled, the poor—has come to the forefront of national policy; changing technology has altered the pattern and the balance of our manpower needs and resources; our population has become increasingly mobile; costs of living have climbed steadily, and the general standard of living has climbed with it. Evaluation of the adequacy of Federal retirement systems has to be made in the context of these developments as well as of the interest of individual employees and of Government as employer.

The three systems with which this report is primarily concerned²—those for the civil service, the Foreign Service, and the uniformed services—all had their genesis in an urgent management need to improve staff by removing those who were disabled, or so old and feeble that they could no longer perform efficiently, thereby opening up appointment and promotion opportunities for younger, more vigorous workers. Their social objective of assuring individuals a reasonable measure of economic security after separation from Federal service was at first a means to the primary end of improving the work force. Gradually, however, they have grown into complex and loosely coordinated systems intermingling staff retirement and social insurance concepts.

MSR and FSR still serve management's needs first and the individual's only secondarily. CSR's emphasis on the once-paramount objective of improving the work force, however, has been much diminished; Federal managers' major complaint about it is that it is unresponsive to legitimate needs of the organization.

Despite frequent revisions, almost always in the direction of liberalization, there are still significant gaps in the protection the three systems afford their intended beneficiaries. Understandably, these beneficiaries and their representatives press hard for closing the gaps and are especially concerned about improving survivorship provisions and provisions for postretirement adjustment of benefits.

All of the systems are costly and, even without the liberalizations advocated by retirees and prospective retirees, costs are soaring. Benefits already earned but not yet payable will in a few years require additional appropriations amounting to billions of dollars annually. Rising costs of living, to which benefit adjustments are now tied by law, will add more millions to the future liability. So will future salary adjustments. Similar problems trouble most of the smaller staff retirement systems, including those for teachers, policemen, and firemen of the District of Columbia government. Retirement system financing has therefore become a major problem to executive branch officials and to Congress, as well as a matter of serious concern to thousands of individuals who fear that the economic security they have been counting on for their old age is slipping away.

Against this general backdrop, facing the need for decision on numerous specific retirement legislative proposals, and recognizing the dearth of adequate current data on and analysis of retirement problems and systems, the President directed the Committee to review "the whole structure of our retirement policies * * * as to objectives, coverage of both civilian and uniformed personnel, benefit patterns, financial soundness, and overall consistency," in order to help establish "up-to-date guides for use in the executive branch in considering proposed changes and further improvements in retirement plans" for the Federal service. This we have done.

OBJECTIVES

The primary objective of Government's staff retirement systems should remain what it was originally: to help improve staff or, put in more current terms, to

² For brevity, CSR will stand for the civil service retirement system or civil service retirement. FSR will refer to the Foreign Service retirement and disability system or Foreign Service retirement. MSR will refer to the military retirement system which is concerned with all the uniformed services (see footnote 1).

make a positive contribution to that pursuit of excellence which is the fundamental purpose of the personnel systems in which they operate. To make such a contribution, a retirement system must remove, in an orderly and humane fashion, the superannuated, the incapacitated, and those who for other reasons have become unable after years of service to do the current job. Otherwise the whole flow of promotion and succession to which recruitment, training, and assignment of younger people are geared will be blocked and the most vigorous and productive individuals, finding themselves stalemated, will leave the service, or never be persuaded to enter it in the first place.

This primary retirement objective is essentially an employer, or management, objective; and, since the employer in this case is the public, the management purpose cannot be lightly regarded. Operating managers, rightly, look to Government's staff retirement systems to—

- Keep appointment and promotion opportunities open, so that a force of the vigor and initiative required to accomplish the agency's assignments efficiently and economically can be maintained;

- Help maintain the Government's competitive employment position and reduce expensive employee turnover;

- Induce able and still productive men and women to remain in the service through the peak of their productivity;

- Ease adjustments in the size or composition of the force as required to accommodate to the impact of automation, occupational shortages and surpluses, retrenchment, change in mission, and other dislocating conditions;

- Be reasonably flexible and administratively usable.

Military management looks to MSR, in addition, to provide both an effective incentive for Reserves to keep themselves trained and available for active duty during emergencies and a flexible mechanism for recalling qualified personnel when rapid and extensive expansion of the Armed Forces is required.

For employees, the primary objective is an adequate postretirement income, but they seek other important values, too. Today's employees look to staff retirement systems to—

- Open employment and promotion opportunities for them during their working years, through orderly removal from the work force of older employees of higher rank;

- Preserve their retirement protection when they change jobs, locations, or employers;

- Allow them some measure of personal choice about when they retire, but protect them against involuntary retirement;

- Provide an adequate income to them (and their families) after employment ceases, whether separation from employment is owing to age, disability, involuntary separation, death, or their own choice;

- Maintain the purchasing power of the postretirement income;

- Cost them little;

- Be equitable and just.

The public, too, has a sizable stake in Government's staff retirement systems, a stake going even beyond its employer interest in increased efficiency of the work force. To the extent that retirement incomes are adequate, Federal retirees, as well as other retirees, remain customers of those who produce goods and services and so contribute to economic stability rather than become public charges; there is a point, therefore, where a saving on retirement system costs may not be an actual saving when weighed in the light of a possible future drain on general revenues for welfare purposes. Also, to the extent that the Federal Government's staff retirement systems reflect the manpower, economic, and social policies that Government advocates for others, the systems work toward full effectiveness of those policies and set a good example for other employers. From the standpoint of public policy, therefore, Government's staff retirement systems should—

- Contribute to efficiency and high productivity in Government operations;

- Foster optimum utilization of manpower resources and potential;

- Promote labor mobility by preserving retirement protection when employees change jobs, location, or employer;

- Help maintain national purchasing power by assuring continued income for those whose work has ceased;

- Be fiscally feasible.

PROBLEMS AND ISSUES

Even a casual consideration of these manifold objectives points up the conflicting interests that must be balanced by retirement planners and decision

makers. Management needs to hold some employees and to retire others, to keep career opportunities open and at the same time reduce turnover, to achieve stability but foster mobility. The preferences of individual employees often clash with the needs of management: those who wish to retire early are frequently the ones management would most like to hold, and others whom management should be able to retire may stay on for years. For the good of Government and of the public, agencies urgently need authority to retire some civil service employees, especially those in managerial jobs, who importantly influence performance and morale of other employees throughout the organization. (Such authority has long been available to, and used by the Foreign Service and the uniformed services.) But more selective (or flexible) retirement policies would require a discrimination among individual employees which civil service managers, surrounded by procedural requirements designed to protect employee interests, have traditionally been reluctant to make except in the most extreme cases and which they assuredly will not make in the case of retirement if the needed management authority is loaded with procedural safeguards.

Special demands of certain occupations in which only the young, alert, and physically superior can perform satisfactorily require both earlier-than-usual retirement provisions and some practical means of making second careers available to those who, retired early from such jobs, are disadvantaged by age and, at times, nontransferable skills. For other occupations, however, there is need for retirement provisions which permit, or even require, service long enough and late enough in life to insure that the employer investment in training and development of employees is fully realized, that productive older workers are not discarded, and that second careers are not economically necessary.

Involuntary retirements under other conditions—selection out of the less effective in the Foreign Service, separations due to base closings, displacements resulting from automation—pose special problems. What are the dimensions of the employer's responsibility in such cases? Does severance pay or a readjustment allowance adequately fulfill that responsibility? At what level should the benefits be set for those who are eligible for early retirement? Industry appears to be trending toward premium benefits for employees who retire early because of work force adjustment or company pressure on those considered less productive; are such provisions justified in terms of their contribution to the productivity of the organization or do they, without adequate justification, reward the less valuable employees and penalize the more valuable ones?

Benefit levels, and methods of determining those levels, are matters of continuing concern to beneficiaries of the retirement systems and to Government. Government is committed to the principle of pay comparability for civilians and to an equitable relationship between civilian and military pay. We must, when it becomes possible, extend this principle to encompass comparability of total compensation, including retirement and other fringe benefits. But reliable (or even usable) data on fringe benefits prove extraordinarily difficult to pin down,³ and such data as have been obtained are in terms of employer costs rather than of benefits received, which is what is important to those being compensated. Another difficulty is that the comparability principle promises, in theory, at least, comparable compensation for comparable responsibilities. Special conditions, however (e.g., combat duty in the case of the military, conflict-of-interest requirements, restrictions on off-the-job conduct and activities, inability to negotiate directly for wage and benefit increases, and inability to strike), limit the extent to which Federal service, and its compensation, can be considered comparable to that of private industry. Perhaps the comparability principle is, for now and until more valid data are obtainable, best applied only to the major elements of compensation, leaving the others to find their own levels in a way that hopefully will result in a reasonable, if not exact, overall balance.

Methods of financing and funding the retirement systems vary: some are contributory, some (technically at least) noncontributory; some are fully funded, some partially funded, and some pay as you go. Disagreement continues unresolved over the extent to which the individual should share retirement costs and over the best approach to financing. Methods of resolving these problems will have a tremendous impact on the administrative budget of the Government, as well as on the sense of security of hundreds of thousands of persons who depend on their Federal retirement benefits for economic security in their old age.

To complicate things still further, Government has no commonly held concept of what "retirement" is. Quite possibly it needs none, considering the various

³ The 1963 fringe benefit data gathered by the Bureau of Labor Statistics for pay comparability purposes were extremely difficult to obtain and proved to be of doubtful general validity. The effort has not been repeated.

objectives retirement is expected to serve. The fact remains, however, that to some parts of Government retirement mean withdrawal from the Nation's work force; to others, it is withdrawal from a particular personnel system; and, to still others, it is something in between. Social security, for instance, does not generally pay benefits to those who have substantial earnings from work; the civil service annuity, except in the case of certain disability retirees, is paid in full, regardless of how much its beneficiaries may be earning (though salary may be correspondingly reduced if the annuitant is reemployed by Government); and MSR requires its regular officers, but not its Reserves or enlisted personnel, to forfeit a portion of their retirement pay (but not their salary) if they accept civilian employment in the Federal service, but not if they work for other employers. Such differences importantly affect efforts to assure uniformity and equity in treatment of various categories of workers.

CHANGING CONCEPTS AND PHILOSOPHIES

Underlying and emphasizing many of the differences in objectives and the difficulties in finding suitable solutions is a loose set of concepts and national attitudes still very much in transition. Formal retirement itself is a relatively new phenomenon in our society, and we are still quite ambivalent about it. The concept of the right, and also the obligation, to work is deeply embedded in our social conscience and national philosophy. Though this value orientation may need changing, and probably is changing, it has nevertheless not yet changed to the point that all can live comfortably with whatever philosophy may succeed it. Some people accept, and look forward to, retirement as a hard-won rest, a welcome release from the tensions and responsibilities of the workplace, a long-awaited opportunity to live instead of to make a living. Others regard this attitude as an indication of shiftlessness which one ought to be slightly ashamed of. There are some who, deeply imbued with the work ethic or unable through circumstance or choice to have learned not to work, approach retirement with dread and put it off as long as possible; to them retirement means loss of irreplaceable work interests and social relationships, a diminution of social status and of self-respect, a life devoid of future purpose and achievement. To others, such an attitude suggests social impoverishment and lack of personal resources.

The social security program, probably more than any other single force, is changing some of our old attitudes. It operates on the philosophy that those who have worked are entitled someday to stop and to receive a continuing, though reduced, income as a right earned through their past labors. It secures this right to practically all the gainfully employed (and will soon expand that right to include basic hospital care for all who are subject to its coverage). Workers and employers are expected to share costs equally, benefits are paid without regard to means tests (though there is an annual earnings test), and the program operates under benefit formulas and provisions designed to give relatively larger cash benefits to those who need it most—those with lower incomes and those with a larger number of dependents. The social-equity principle illustrated by this latter feature, and by medicare, is quite different from the individual-equity principle on which Government's pay and retirement systems were originally based and has importantly influenced revision of the retirement systems⁴ along social insurance lines in recent years. Deliberately designed to replace only in part the earnings cut off by old age, disability, or death, the social security program leaves a substantial role for personal insurance and savings, and for supplementary pension and retirement plans constructed to meet special needs and provide special incentives.

The concept of the staff retirement benefit as a gratuity, or even as a reward for long and faithful service, has given way through the years to the concept that it, too, is a right earned through past service. But the nature and dimensions of this right are still unclear. The civil service employee has no retirement contract and, although he is given a certificate of membership setting forth his retirement rights, the certificate bears a caveat that these rights are subject to change by legislation (since most legislation is liberalizing, however, he probably does not want a binding contract). Military retirement rights rest on even slier contractual bases since the member makes no direct contribution toward retirement costs, his imputed contribution has never been precisely identified or even universally acknowledged, and he can point to no specific sum as representing his equity or even the consideration in return for which his employer owes him something.

⁴ This is especially true of CSR, the members of which are the only large group not covered by social security and so lack the protection of its social insurance features.

The dimensions of the retirement right are equally unclear. Is it a right to the retirement benefits which were offered to the employee at the time he came to work? Or to the benefits offered to him at the time of his separation? Or perhaps to the benefits made available to those retiring later? Our concepts of its dimensions are clearly in transition, as evidenced by the variety of methods and standards that have been used and proposed over the past two decades to adjust benefits of those who have already retired.

The concept of the retirement benefit as deferred compensation has been widely discussed in recent years. If this view is fully accepted, what are the implications so far as contributory versus noncontributory financing of retirement systems is concerned? The implications for immediate and full vesting? If the retirement benefit is in fact deferred compensation—a benefit promised in lieu of more take-home pay—how can we justify a situation in which the great majority of those who enter the military service receive neither retirement benefits (because they do not serve long enough) nor return of that part of their pay that was deferred to help cover the cost of a possible future benefit? And how large a proportion of his compensation can any employee afford to have tied up in forced contributions (direct or otherwise) for increasingly costly future benefits at a time when the expenses of providing for his family and educating his children are heaviest?

Each of the ideas mentioned above, as well as many more not explored here, has influenced development of our present retirement practices. Clearly, no one social or economic philosophy can adequately explain all of the changing currents of the retirement movement. The society in which our retirement systems were originally designed was relatively static; today's society is characterized by a dynamism that we have not yet learned to assess adequately, much less cope with, and our retirement systems show the strains of the continuing effort to accommodate to this dynamism.

CONCLUSION

This, then, is the setting for the retirement problems the Committee has been studying. If Government's staff retirement systems are inconsistent with each other, complex, and costly—and they are all of these—there is some reason for it:

They are inconsistent because each attempts to cope with a particular set of employment conditions specific to some but not applicable to all who serve the Nation's largest and most diversified employer; they must continue to meet those special conditions if retirement is to serve its purposes for those employees and make a positive contribution to Government's missions.

They are complex because they attempt to balance divergent interests, accommodate conflicting values, and adjust to continually changing manpower needs and policies; they must continue to do so because that is what our democratic system demands of its public institutions.

They are costly because, despite their various inadequacies, they are essentially generous; they must remain so if Government is to be a responsible employer.

Moreover, they cannot be substantially modified without affecting the larger personnel and management systems of which they are an integral part.

Despite all this, Government's staff retirement systems should, and can, be made more consistent, more rational, somewhat simpler, and considerably more effective. In our search for improvements, we have assessed both existing systems and possible changes against a set of objectives and principles which represent the considerations we hold most important and which rest on the convictions that—

Federal staff retirement systems, either alone or in combination with other benefit systems, must provide income sufficient to permit the employee and his family to live in comfort and dignity upon completion of a full career of work.

Retirement should be viewed, and used, by Government both as a management tool and as an instrument for advancing social goals.

Staff retirement systems must provide reasonable flexibility and will inevitably involve some compromise of conflicting interests, if they are to serve their various purposes.

Government's retirement policies and practices, like its other personnel management policies and practices, should keep pace with those of large, progressive employers in the private sector.

We commend the following statement of objectives and principles to the President and to the Congress as guides for the development and improvement of staff retirement systems for those who serve the Government:

PROPOSED RETIREMENT POLICY

Federal staff retirement systems, as integral parts of the larger personnel management systems in which they function, should (1) help Government maintain efficient civilian and military forces and facilitate adjustment of those forces to changing manpower needs, resources, and policies; and (2) provide protection for civilian and military personnel, and their families, against the economic hazards of loss of employment, old age, disability, and death. The importance of these objectives and the need to achieve them with proper regard for costs and for consistency of treatment among categories of employees require that further development of Federal staff retirement systems be guided by certain commonly understood principles. It is therefore declared to be the policy of Government that:

1. Staff retirement systems shall be developed and maintained for the mutual benefit of Government and the individuals who serve it. Changes in the systems should benefit both Government and employees, and all proposals for change shall be measured against this yardstick.

2. Each staff retirement system shall be so structured as to help the statutory personnel system in which it operates maintain a force that is effective for its particular mission. Within this requirement, retirement provisions and benefits for Federal personnel shall be uniform to the extent achievable, and proposed revisions in any staff retirement system shall be evaluated in relationship to their implications for other systems.

3. The principle that pay of Federal civilian employees should be comparable to that of employees doing similarly responsible work in private enterprise shall be extended to apply to total compensation, and an equitable relationship shall be maintained between military and civilian total compensation. In considering possible changes in either pay or fringe benefits, primary attention shall be given to maintaining comparability of total compensation.

4. Staff retirement benefits shall be fairly and directly related to length of service and preretirement basic earning rates, except that appropriate minimum benefit levels shall be maintained to (a) offset the effects of short service due to disability, death, or special occupational requirements; and (b) generally assure for civilian employees and their families a benefit (in combination with any social security benefit that may be available to them from employment covered by the social security system) at least equal to that which would be available had their Federal employment been covered by social security.

5. Benefits after retirement shall be promptly and automatically adjusted upward when costs of living rise, in order to maintain the purchasing power of annuities and retirement pay, and the same adjustment formula shall be applied by the various systems.

6. Provisions for financing and funding Federal staff retirement systems shall be so designed and administered as to

(a) Require Government and employees to share normal costs, including those resulting from future liberalization of benefit provisions; military personnel, whose active-duty pay is traditionally discounted to provide an imputed retirement contribution, are deemed to be contributors just as if they contributed directly.

(b) Identify clearly and recognize Government's responsibility for other costs, including those for past-service liability and those for post-retirement adjustment of benefits.

(c) Provide for maintenance of each retirement fund at a predetermined level sufficiently high to assure that all retirement benefits can be paid promptly as they fall due.

7. Whenever a staff retirement system is changed, provision shall be made to protect the equities of any individuals who would be adversely affected by such change.

All future proposals for change in Federal staff retirement systems shall be considered in the context of their contribution to the objectives and their adherence to the principles here stated.

SCOPE OF STUDY AND REPORT

The dramatic increase in the proportion of older persons in the population; the economic, social, and political problems growing out of this development; and our Nation's resolve to provide, in one way or another, economic security for the aged are already so well documented that they require no further treatment by this Committee. Rather, we have concentrated on the three staff retirement systems that cover most of the Federal work force, with particular attention to

the respective objectives, the overall consistency, and the financial soundness of those systems and to problems of common concern to all of them.

Two of the retirement systems, FSR and MSR, are so intricately and intimately a part of the personnel systems in which they function that no thoroughgoing evaluation of them can be made without evaluating the total effectiveness of each personnel system, and no substantial change can be made in their basic retirement concepts and provisions without making corresponding changes in recruitment, retention, provisions for career progression, and force management in general. Neither time nor charter has permitted a study of this scope. Recommendations concerning these two systems, therefore, are confined to changes which can be put into effect without fundamental revision of the personnel systems involved.

The public hearings held by the committee, together with the considerable volume of correspondence it received, have provided many useful ideas and topics for study; a number of these are treated briefly in part I and in the staff annex. All were given appropriate consideration by the committee.

Our major findings and recommendations are summarized in part I; these recommendations, if effected, will substantially improve those situations that are of most concern to employees and to managers of Federal programs. Part II, the annex to this report, reviews the three major Federal staff systems in detail and major non-Federal systems in summary; deals with problems of common concern, including financing; and sets forth certain historical and statistical detail.

PART I. RECOMMENDATIONS

A. 1. CONTROL OF COSTS OF RETIREMENT AND OTHER FRINGE BENEFITS

Recommendation

Expenditures for fringe benefits for all Federal personnel should be identified and controlled. The policy of comparability should be applied to total compensation as well as pay of civilian personnel: In support of this policy, procedures for gathering data and comparing costs should be improved. An equitable relation between military and civilian benefits should be maintained, taking account of the special requirements of military forces.

Discussion

Fringe benefit expenditures have grown rapidly in recent years in both Government and industry. They now amount to about 25 percent of civilian salaries and wages; the proportion in military compensation appears to be even higher. The magnitude of these expenditures requires improvement of control.

Legislation has established the policy that salaries and wages of Federal civilian employees should be comparable to pay for similar work in industry. Efforts are made to maintain military pay in an equitable relationship with civilian salaries and wages. No policy has yet been developed with respect to fringe benefits for either civilian or military personnel, and the Government has had only limited experience in collecting and comparing data on costs in Government and industry. The President's Special Panel on Federal Salaries recommended last year that all nonsalary elements in Federal compensation be analyzed and taken into account; it further stated that benefit expenditures should be kept under careful and continuous examination, and that there should be substantial equality between Federal and non-Federal employees with respect to benefits as well as pay. This Committee concurs in the recommendation and views of the Pay Panel and urges action to attain substantial equality in total compensation as rapidly as possible.

The Bureau of the Budget should be made responsible for monitoring expenditures for compensation of all kinds, with the Civil Service Commission, Department of Defense, Department of State, and Department of Labor closely supporting this effort. Fringe benefit costs should be clearly identified, and the trend of expenditures should be carefully examined. When new or liberalized benefits are proposed, their relation to other benefits, implications for other systems, and effect on total compensation should be ascertained. This work should provide clear definitions of benefits and costs which would help Government to regulate compensation levels and help employees to evaluate them.

Simultaneously, the Department of Labor should resume and expand the work previously done in collection of data on fringe benefits in industry and should assist the Bureau of the Budget and other collaborating agencies in improving methods for comparing expenditures in Government and industry. At present, pay comparisons can be made reliably and clearly; but data on fringe benefits in industry has been hard to get and harder to interpret:

Benefits have grown rapidly, often on a piecemeal basis, and measures for cost accounting and management control have been outpaced.

Practices in industry vary significantly—by industry, region, pay level, and production versus nonproduction workers—and a solid base for comparison is hard to establish.

Expenditures for retirement plans require particular inquiry because they may reflect financing and tax policies rather than values of benefits and ultimate costs.

Data now available on fringe benefits appear to indicate that Federal expenditure rates are approximately equal to industry rates for white-collar employees. However, problems such as those cited must be resolved before comparisons warrant confidence. Efforts to improve the methods of comparison must be expanded; and as rapidly as reliable information becomes available, it should be used as a guide for equalizing total compensation of Federal and non-Federal employees.

Military benefits appear to represent a percentage of gross payroll higher than civilian benefits in Government or in industry. Medical and retirement benefits appear to cost relatively more; these expenditures reflect force management policies designed to keep forces young and vigorous. Relative costs of all civilian and military benefits should be ascertained on a common basis, so that the relation between systems will be equitable in light of the special requirement of each service.

A note about estimated costs: Except where otherwise indicated, cost estimates given in the attached recommendations pertaining to Federal civilian employees were computed on a normal-cost-plus-interest basis.

"Normal cost" means the cost of benefits being earned now and to be earned in the future, expressed as a level percentage of salary to be paid into the retirement funds each year for each employee in the service. These amounts, together with interest they earn when invested, will fully cover prospective cost of the benefits for employees and their survivors.

"Plus interest" means money needed as annual income to replace the additional interest that the retirement funds would have earned if all payments to cover normal costs had been made on time in the amounts required to fully cover prospective costs, and had then been invested.

The "annual" costs of estimates computed on this basis are long-term averages and are generally much higher than actual first-year expenditures would be.

Cost estimates given in the attached recommendations pertaining to the uniformed services were computed on a normal-cost basis, since there is no retirement fund, and interest does not therefore come into the picture.

All estimates make allowance for normal career progression of wages but do not attempt to anticipate future general wage increases or changes in the size of the active force.

General wage increases have the effect of increasing benefits payable in behalf of the current work force without providing sufficient revenue to cover the full cost of such benefit increases.

Increases of the work force result in the expansion of the retired rolls and a proportionate increase in aggregate benefits.

A. 2. FINANCING

(a) *Financing and funding of CSR and FSR*

Recommendations

(1) Normal cost financing through equal employee-agency contributions should be retained with respect to existing benefit structure. The normal cost of future benefit liberalizations in behalf of the active work force should be shared equally by employees and agencies and should be reflected in the upward adjustment of contribution rates.

(2) The cost of future incremental unfunded liability that results from—

- (a) Benefit liberalizations for the active work force;
- (b) Liberalizations for annuitants, other than Consumer Price Index adjustments;
- (c) Extension of coverage to new groups of employees;
- (d) Wage increases

should be fully financed by Government through direct appropriations to the fund annually over a 30-year period in accordance with progressively increasing amortization schedule enacted into law.

(3) Direct appropriations under permanent indefinite authority should be made in amounts sufficient to peg the fund balance at whatever maximum level it might

attain under this recommendation or at employee equity,¹ whichever is the greater.

(4) The civil service and Foreign Service funds should be merged, but the separate identity of each system should be continued.

Discussion

The foregoing recommendation would completely cover normal cost, would automatically neutralize prospective causes of future financial deficiency (including future general wage increases) as they occur, and ultimately would stabilize the existing unfunded liability of the system. The mechanics of the recommendation require virtually full disclosure of retirement costs and explicitly allocate responsibility for such costs to (1) employees and agencies jointly, (2) agencies only, and (3) Government, as distinct from agencies.

Briefly, normal cost of existing benefits and future liberalizations thereof would be shared equally through employee-agency contributions. Future CSR changes designed to improve management would require an increase of the agency contribution rate by an amount sufficient to cover the full normal cost of the change. The unfunded liability resulting from liberalizations, wage increases, extension of CSR coverage to new groups of employees, increases granted to annuitants already on the rolls (except for CPI adjustments), or other changes would be financed entirely by Government by direct appropriations annually in accordance with the following schedule:

30-installment, increasing-payment amortization schedule for \$1,000,000 at 3½ percent interest—First payment due immediately upon creation of unfunded liability

Year	Annual payment	Year	Annual payment
1.....	\$4, 051	17.....	68, 869
2.....	8, 102	18.....	72, 920
3.....	12, 153	19.....	76, 971
4.....	16, 205	20.....	81, 023
5.....	20, 256	21.....	85, 074
6.....	24, 307	22.....	89, 125
7.....	28, 358	23.....	93, 176
8.....	32, 409	24.....	97, 227
9.....	36, 460	25.....	101, 278
10.....	40, 511	26.....	105, 329
11.....	44, 562	27.....	109, 380
12.....	48, 613	28.....	113, 431
13.....	52, 665	29.....	117, 483
14.....	56, 716	30.....	121, 534
15.....	60, 767		
16.....	64, 818		
		Total payments.....	1, 883, 774

Annual payments required under the above schedule are based on an arithmetic progression in ascending order. The amounts due each year after the first are simple multiples of that first amount. The schedule was designed so that the present value of these payments, based on 3½ percent interest, equals \$1 million. In addition, the schedule produces full funding of the increased benefit payments attributable to unfunded liability over 30 years, and at the same time, avoids large accumulations in the early years.

Authorization for annual appropriations in accordance with the enacted amortization schedule would be specifically provided in all future pay-raise or liberalizing legislation. The resulting annual appropriation request submitted to the Congress under this authority would be sufficient to cover all scheduled amounts due in that particular year. Thus, new obligational authority and concomitant budget expenditures would be shown in the annual budget only as expected benefit payments from the CSR fund begin to reflect liberalizations, pay raises, etc.

Finally, the future effect of the current unfunded liability together with the costs of CPI increases to annuitants would be covered through direct appropriations designed to peg the fund at whatever maximum level it might attain under this recommendation, or at employee equity, whichever is greater. Permanent indefinite authority contingent on the stipulated peg point would be immediately requested of the Congress. Encroachment on the margin of safety established by the peg point would thereafter automatically require an appropriation request in the necessary amount.

¹ The total of active employee contributions, contributions of employees separated with vested rights, and beneficiary contributions net of benefits paid in their behalf.

Enactment of the committee recommendations herein proposed for CSR to become effective January 1, 1967, would require combined employee-agency contributions to be increased by $1\frac{1}{2}$ percent, from 13 to $14\frac{1}{2}$ percent of payroll. Approximately two-thirds of the required increase is attributable to liberalizations, the normal cost of which would be shared equally by employees and agencies through an immediate increase of contribution rates by one-half of 1 percent each from $6\frac{1}{2}$ to 7 percent. Effective July 1, 1969, a further one-half of 1 percent increase in agency contribution rates, from 7 to $7\frac{1}{2}$ percent, would be initiated to cover the cost of recommended changes designed to improve management (and therefore not appropriate for employee sharing). In addition, a direct appropriation to the fund of \$6.1 million would be required, as of the January 1, 1967, effective date, to cover the first one-half-year amortization cost in accordance with the foregoing prescribed schedule.

(b) Administrative costs of retirement

Recommendation

The administrative costs of the retirement systems administered by the Civil Service Commission should be financed from the civil service retirement and disability fund in a manner similar to arrangements currently applicable to Federal employee insurance programs. Hereafter, a single limitation covering all administrative costs would be authorized annually, which would be assessed against the appropriate funds on the basis of the Civil Service Commission's estimates of relative costs.

Discussion

As is the case with the administrative costs of the insurance programs, decentralization of retirement system administration precludes full trust fund financing of such costs. The recommended single trust fund limitation without reference to the pro rata shares would afford much needed flexibility. It is estimated that this proposal would finance retirement administrative costs of about \$4 million annually in addition to about \$1.7 million for the administration of the insurance programs.

(c) Financing of MSR costs

Recommendation

Pending completion of the Department of Defense force management study, it is recommended that accrued retirement costs be reflected annually in total obligational authority; however, annual appropriation requests shall continue to reflect only those retirement costs expected to materialize in the budget year.

Discussion

This is in line with the expected scope of the force management study which, among other things, will presumably clarify the concept of imputed contributions from active duty pay toward the cost of the fringe benefit package (including retirement, health care, etc.), and will provide a rational basis for inter-system comparisons.

Cost data—Committee recommendations

[In thousands]

A. Civil service retirement system 2. Financing d. Cost summary	Total level cost ¹	Normal cost			Incremental unfunded liability (without interest)
		Total	Agency share	Employee share	
(1) CSR COSTS					
A.4.b. Social security minimum-----	\$85,000	\$59,500	\$29,750	\$29,750	\$729,000
A.5.a. Survivor: Age 22-----	400	200	100	100	6,000
A.5.b. Survivor: Remarried widow-----	14,100	8,000	4,000	4,000	174,000
A.8.b. Disability retirement-sick leave-----	² 5,800	² 3,300	3,300	(²)	71,000
A.10. Eliminate voluntary contributions-----	-13	-7	-4	-3	-170
A.11. Required deposits and redeposits-----	2,000	1,000	500	500	29,000
B.1.(b) 65/5 selective retention-----	71,000	40,500	40,500	(³)	871,000
B.1.(d) 55/30-60/20-----	23,000	13,100	6,550	6,550	283,000
B.3. Survivor: Minimum-----	26,500	17,200	8,600	8,600	266,000
B.4.a. Restored earnings-disability-----	-200	-100	-50	-50	-2,900
B.6.b. CSR credit: foreign nationals-----	8				230
B.6.c. CSR credit: National Guard technicians-----	⁴ (57,600)	⁴ (37,400)	(⁴)	(⁴)	577,200
Total allocable cost of retirement recommendations-----	227,600	142,700	93,200	49,500	3,003,360
As percent of payroll-----	(1.418)	(0.889)	(0.581)	(0.308)	(⁵)
Financing recommendations:					
Contribution increase required to cover normal cost of existing benefit structure, allocated among all agencies and employees-----	⁶ 78,600	78,600	39,300	39,300	(⁶)
Interest on the existing unfunded liability ultimately covered by direct appropriations designed to peg the fund. (Cost to Government only; not allocable among agencies.)-----	⁷ (\$1,400,000)	(⁸)	(⁸)	(⁸)	(⁸)
Total allocable cost-----	306,200	221,300	132,500	88,800	3,003,360
As percent of payroll-----	(1.908)	(1.379)	(0.826)	(0.553)	(⁹)
Current service cost					
(2) OTHER BENEFITS					
A.4.a. Transfer of credit-----		⁸ (\$198,000)	(⁸)	(⁸)	
A.4.c. Medicare tax-----		⁹ 138,000	⁹ \$69,000	⁹ \$69,000	
A.6. Increased group life insurance and improved financing-----		33,000	11,000	22,000	
A.8.b. Annual agency savings from sick-leave recommendation-----		² -7,500	² -7,500	(²)	
B.6.c. National Guard life and health insurance-----		⁴ (9,143)			
Total allocable cost of other recommendations-----		163,500	72,500	91,000	
As percent of payroll allocated among all agencies and employees-----		(1.019)	(0.452)	(0.567)	
SUMMARY					
Total annual allocable normal and current service cost [(1)+(2)]-----		384,800	205,000	179,800	
As percent of payroll-----		(2.398)	(1.278)	(1.120)	

¹ Annual payments to the fund required to cover normal cost plus interest on the unfunded liability. Relates to cost estimates provided for each recommendation.

² Increased cost to fund assessed entirely against agencies would be more than offset by agency saving of \$7,500 annually.

³ Not appropriate for employee sharing. Recommended as tool of management and not as benefit liberalization.

⁴ NON-ADD. CSR normal cost of existing benefit structure, \$37,400 (13.49 percent National Guard payroll) shared equally by DOD and employees in identical manner as with any new hires. Life insurance and health benefit costs shared similarly under standard rates applicable to all employees: \$3,500 by DOD and \$5,643 by new employees. Total annual DOD share for retirement, life insurance, and health benefits would be \$22,200, an increase of \$8,500 over the \$13,700 currently expended for these purposes.

⁵ Not available.

⁶ Assumes part III of Public Law 87-793 financed from the fund rather than by direct appropriation.

⁷ NON-ADD. Ultimate cost to be covered by pegging.

⁸ NON-ADD. Covered under combined contributions currently made to the fund and would not require any increase. Ultimate transfer to Social Security Administration of employer's share (in addition to the amount withheld from employee refunds for whom credit is transferred) is an added cost to the fund that would be financed by the direct appropriation required to peg the fund at the stipulated level.

⁹ Direct tax levied equally against agencies and employees; assumes full election of coverage and would increase to ultimate of \$220,000 in 1986. As percent of payroll, would increase annual current service cost for this item from 0.43 percent each in the first year to about 0.69 percent.

A. 3. MAINTAINING PURCHASING POWER OF ANNUITIES AND RETIRED PAY

Recommendation

Federal staff retirement systems should continue the policy of maintaining the purchasing power of civil service and foreign service annuities and military retired pay by prompt and full increases when the consumer price index rises. Additional increases in benefits are unwarranted.

Discussion

The Postal Service and Federal Employees Salary Act of 1962 established for CSR a policy of maintaining the purchasing power of benefits and authorized automatic increases when the CPI for a calendar year exceeded a base year by 3 percent. A similar policy and procedure were enacted for military retired pay by the Military Pay Act of 1963. In 1965, further acts (Public Law 89-205 and Public Law 89-132) provided for speedier response to CPI changes by authorizing increases when the CPI rose by 3 percent for a period of 3 months.

The House Committee Report No. 529, dated June 17, 1965, stated:

"It is the responsibility of the Government to maintain the annuities of its retirees and survivors at a level that will give them a living comparable to what they had, and rightfully expected to have, at the time of retirement."

This policy is fair and generous. It provides a measure of stability and security rarely matched by any other form of income. Some State systems and a few industry plans have adjusted annuities to cost of living, but automatic adjustment, prompt and complete, is virtually unknown outside Federal staff retirement systems. Social security benefits, the mainstay of employees in the general economy, have no such safeguard. Public Law 89-97 increased social security benefits by 7 percent in 1965 in recognition of the rise in costs since 1959; but it provides for no further action in the future.

In the absence of such a policy, annuity adjustments have been a difficult and time-consuming problem for the past 20 years. Inflation during and after the war diminished the value of benefits. Congress raised annuities by a series of acts, from 1948 to 1965, but the results have been uneven. Had the present policies for adjusting benefits been in effect, wartime controls would have required their temporary suspension; but with the postwar growth of civilian production they would have restored and maintained benefit values more promptly and equitably than legislative adjustments have been able to accomplish.

The current policy for maintaining the purchasing power of retirement benefits covers CSR and MSR and has recently been extended to FSR, but, by an accident of timing, under the formula of the 1962 and 1963 acts rather than the more liberal version enacted for CSR and MSR in 1965. To achieve equity and uniformity among the systems, the current civil service and military formula should be adopted for the Foreign Service as recommended in recommendation C. 4.

In recent years, salary levels have risen faster than living costs. New annuities reflect recent salary levels, and as a result they exceed the benefits of earlier years. Proposals have been made to raise all benefits with each increase in salary levels, as recomputation was formerly practiced under MSR. The result would be that the standard of living of annuitants would not only be maintained after retirement, but would be raised. This proposal would go beyond the policy stated by House Committee Report No. 529, cited above; and it would violate the policy of comparability of total compensation by requiring expenditures to pay benefits far above the level in non-Federal employment. The present automatic adjustment plan maintains the purchasing power of benefits. Further liberalization is unwarranted.

A. 4. RELATIONSHIP TO SOCIAL SECURITY

(a) *Transfer of credits*(b) *Social security minimum**Recommendation*

Employees subject to the civil service retirement or the Foreign Service retirement and disability systems should be assured of survivor, disability, and retirement protection which is at least at the level provided under social security. This basic level of protection should be established through a twofold provision:

(a) Workers who have employment subject to either of these Federal staff retirement systems but die or become disabled before they are eligible for protection under their staff retirement system or leave the Federal service and do not have protection under the staff retirement system when they die,

become disabled, or reach retirement age, should have their credits under the staff retirement system transferred to social security; and

(b) Employees and their survivors who become eligible for benefits under either of these staff retirement systems should be guaranteed that the benefit amounts they receive under the staff retirement system (or, if they are also eligible for social security benefits, under the staff retirement system and social security together) will be at least at the level that would be payable if their Federal service had been covered under social security.

Cost estimate

- (a) \$99 million annual tax transfer cost to retirement funds.
- (b) \$85 million annually.

Discussion

CSR and FSR have developed virtually independently of the social security system. These systems, like staff retirement systems in private industry, place primary emphasis on adequacy of retirement benefits for long-service personnel. But, unlike workers covered by staff retirement systems in industry, employees subject to CSR or FSR do not have the continuing basic protection afforded by coverage under the general social security system. As a result, there are serious gaps in survivor, disability, and retirement protection, or deficiencies in benefit levels, for large numbers of persons with service under these principal Federal civilian staff retirement systems.

Employees and their families do not have survivor or disability protection under either of these staff retirement systems until the employee completes 5 years of service; thereafter, family protection is likely to continue to be below the level of basic protection provided under social security until the employee has completed long service. Large numbers of workers who shift between Federal civilian employment and other work have serious gaps in their social security protection; they may be without protection at various times, and may reach retirement age without any retirement credit for their Federal service. The Committee recognizes that a plan to remedy these deficiencies based on direct social security coverage of the employment of workers who are subject to the staff retirement systems would be the most effective from the standpoint of assuring a planned and systematic level of benefits for workers who shift between Federal employment and other work. However, proposals under which social security coverage would be extended to such employment, with adjustment of the staff retirement system provisions to take account of the social security coverage, have always proved unacceptable. The Committee believes that the enactment of urgently needed remedial legislation should not be further delayed.

The deficiencies in protection can be remedied, and an adequate relationship between these staff retirement systems and the social security system developed, under a twofold approach involving (a) transfers of credit to social security where the former employee or his survivors are not eligible for staff system benefits and (b) where staff system benefits are payable, a guarantee that such benefits (together with any social security benefits based on other work) will be at least as high as if the Federal employment had been covered under social security.

The Committee believes that the guaranteed benefit level should be generally applicable except in cases involving the surviving spouse of a deceased annuitant who did not elect a survivor annuity based on the full amount of his own annuity, and cases involving certain foreign nationals employed abroad and covered under CSR. Many foreign nationals employed abroad, especially those with short service, would obtain an unwarranted advantage under this guarantee because the level of the guaranteed benefits established under American standards would be unduly high by the standards of many foreign countries. In regard to the recommended transfers of credit, the Committee believes it essential that credits be transferred not only for workers who do not have enough employment to meet the minimum requirements for protection under the Federal staff retirement system, but also for those who are separated after having had enough employment to meet the minimum requirements but lose their protection under the staff retirement system because the employee's contributions to the staff system are refunded to the worker or his survivors. All transfers would be made at the time the risk matures.

Adoption of the recommended twofold approach would assure that employees subject to either of these staff retirement systems, though not directly covered under social security, would nevertheless have protection under social security or at least the equivalent in protection under the staff retirement system. All employees would have the assurance that, if they leave Federal service and lose staff retirement protection, their Federal employment will be credited under

social security, giving them the same continuity of basic protection that is afforded workers who move from one job to another in private industry. This approach would benefit career employees and their families by considerably improving survivor protection up to the time that they have completed long periods of service, and by providing improved disability protection for many workers with families. The plan would not, however, provide unintended large increases in retirement benefits of long-service workers—as might occur under a coverage-coordination plan—and would not duplicate present protection; this approach is therefore the least costly of any which would achieve the desired objective without cutting back benefits provided under present law.

Part of the cost of the transfer-of-credit plan should be borne by those workers who would obtain social security credit for their Federal employment under the plan—those who separate from Federal service and receive refunds of their contributions to the staff retirement system, or who die or become disabled while employed but before completing the minimum period of Federal service required for eligibility for benefits under the staff retirement system. In all such cases, the staff retirement system would withhold from the refunds an amount equal to the social security contributions which the worker would have been required to pay if his Federal employment had been covered under social security. Appropriate arrangements would be developed by the agencies concerned for the transfer to the social security trust funds of amounts sufficient to meet the proportionate cost, attributable to Federal employment, of social security benefits in cases where credits are transferred.

(c) Health insurance protection

Recommendation

Federal employees covered only by a staff retirement system should have health insurance protection after they reach age 65 on the same basis as other workers. This should be accomplished by covering under the health insurance provisions of social security all such present Federal employees who desire this coverage, and all persons who in the future enter or reenter Federal employment that is covered only by a staff retirement system.

For employees and annuitants who become eligible for social security health insurance and who desire broader protection than they obtain under social security, the Federal Government should make available complementary health insurance designed to maintain protection at approximately the level afforded by the Government-wide high-option plans, with the cost being shared by the Government and the participants. Coverage under present plans authorized by the Federal Employees Health Benefits Act of 1959 should be terminated for future entrants who will, of course, qualify for social security health insurance protection.

Cost estimate

If all employees should elect coverage, \$69 million (1967) rising to \$110 million (1987). (To the extent that present employees leave Federal employees health benefits coverage for social security coverage at age 65, there would be some saving in Government cost.)

Discussion

With the inauguration of a national program of health insurance under the Social Security Act for people over age 65 there is an urgent need to develop a systematic relationship between the Federal employees health benefits program and the new national program. We believe that this can be accomplished with advantages for Federal civilian employees and annuitants.

Under present law, social security health insurance will be provided, beginning in July 1966, for almost all workers (including those under the railroad retirement system) other than Federal civilian employees and for the Federal uniformed services and employees of the Tennessee Valley Authority. If a transfer-of-credit plan is adopted, the Federal civilian employment of workers who do not qualify for annuities under a Federal staff retirement system will, in effect, be covered under social security, including the social security health insurance provisions. Many of the present civil service retirees will be eligible for health insurance under social security through a special transitional provision under which the coverage is financed from general revenues.

In addition, many civilian employees whose Federal employment is excluded from social security coverage acquire such coverage through other work; they will be eligible at age 65 for health insurance under both social security and the Federal employees health benefits program, and much of the protection provided

under one program will be duplicated under the other. They will have to decide whether to pay the premiums necessary to continue the comprehensive protection many now have under the Federal employees plan, which will overlap much of the protection they will have under the social security plan.

We know of no valid reason why, over the long run, all civilian employees should not obtain substantially prepaid health insurance protection at age 65 under an arrangement which, while avoiding duplication of protection, permits maintenance of the present high level of their health insurance protection. We therefore believe that coverage under the basic social security health insurance plan—protecting against costs of hospital and related care—should be extended to the Federal employment of workers who are covered only under staff retirement systems. (Participation in the social security supplementary medical insurance plan is open to Federal employees under present law.) Since some present older employees would not want to change their retirement plans in which they rely on their present health insurance to fill their protection needs after retirement, we believe that present employees should be permitted to elect individually not to have their Federal employment covered under the social security health insurance provisions.

If Federal employees were covered under the health insurance provisions of social security, the resultant decrease in the proportion of employees and annuitants who would continue under the Federal employees health benefits plan after age 65 would slow the rate of increase in the future costs of the Federal health benefits program. This, in essence, would effect savings for Federal employees that would in part offset the cost of the Federal employees' contributions to the social security hospital insurance plan. Under the present arrangement, for health benefits purposes Federal employees are in the same general coverage group with some current and most future retirees, with the same premium rates applicable to all members of the group. Employees therefore share the substantially higher cost of insuring elderly annuitants and their dependents. While many of those annuitants and employees who are insured under social security will change from Federal employees health benefits coverage to social security health insurance coverage at age 65, a further increase in the proportion of annuitants in the Federal employees health benefits program can nevertheless be anticipated over the long run. This will add to the cost charged to employees and, with other factors which tend to increase costs, will contribute to the possibility that the program will become unduly expensive and therefore less effective.

The recommended arrangement would assure that over the long run all Federal civilian retirees—the improvident, as well as the provident, and those with low retirement income as well as those who are better off—will have adequate health insurance protection at age 65 that is substantially prepaid. Since the employee and employer, equally, would pay the required social security tax during the employee's working career, the only essential cost after he retires would be the relatively small cost of the contribution for participation in the voluntary supplementary medical insurance plan of the social security program (initially set at \$3 monthly) which would be matched equally by payments from the general revenue.

For those employees who become eligible for social security health insurance protection, and wish to maintain the level of comprehensive protection they had under the Federal employees health benefits program, the Federal Government should arrange for, and perhaps share the cost of, as it does with respect to the present programs for retired employees, complementary group insurance provided by private carriers. Such complementary protection could cover a substantial part of the costs of prescription drugs and medicines, much of the cost of necessary private-duty nursing, the cost of inpatient hospital services to the extent not covered under the social security plan for up to 365 days during a spell of illness, and health benefits for spouses who have not reached age 65. If the employee wants to continue the same level of protection available under his Federal employees health benefits plan, the cost at today's prices for complementary benefits under the indemnity benefit plan would be \$6.80 a month for each person; for the service benefit plan it would be about the same. Once such complementary coverage is made available, eligibility for social security health insurance should, of course, terminate coverage under the health plans now provided under the Federal Employees Health Benefits Act of 1959 for future entrants into the Federal service.

A. 5. OTHER SURVIVOR PROTECTION

(a) *Benefits for student children**Recommendation*

Provisions on eligibility of student children for benefits under civil service and Foreign Service retirement systems should be amended to match social security provisions with respect to (A) eligibility to age 22, (B) retention on rolls for interim persons of 4 calendar months, and (C) entry or restoration on rolls if the child becomes a student after age 18 but before he attains age 22.

Cost estimate

CSR: \$400,000 annually.

FSR: \$8,000 annually.

Discussion

Social security pays benefits to unmarried children who are full-time students until they are age 22, continues benefits for interims of 4 calendar months, and allows benefits to begin or resume if a child becomes a full-time student after age 18 but before he reaches age 22.

CSR pays benefits to student children of deceased members to age 21, except that if the child turns 21 between September 1 and June 30, benefits may be paid until June 30. To cover vacation periods and other absences, benefits may be paid for interims not to exceed 4 months. Consequently, if a student child at a trimester school starts vacation on April 15 with resumption scheduled for August 15, he is carried on the rolls for the whole period. If school is scheduled to resume any later, he is dropped from the rolls. Under OASDI, a student child can be carried on the rolls over 4 full calendar months: if school ends after April 1 and is scheduled to resume before September 30, payments will be made for the whole period (covering all of May, June, July, and August, but only parts of April and September). Further, under CSR a child who starts or resumes student status after reaching age 18 and before age 22 may not be entered or restored on the rolls.

FSR lacks any provision for student children. Benefits cease at age 18 unless the child is disabled. Under MSR, basic protection for children is provided by social security.

This tangle of practices has grown piecemeal. As a step toward uniform standards, the social security provisions should be adopted for CSR and FSR.

A proposal that benefits be paid to all children to some age beyond 18 was rejected. All systems now use age 18 as the general limit except for children who are disabled or are students. The latter exception is intended to encourage educational efforts. A general exception would be an unwarranted cost for all systems.

(b) *Benefits for a surviving spouse who remarries**Recommendation*

Benefits payable to a surviving spouse under the civil service and Foreign Service retirement systems should be continued without interruption where such spouse remarries after attaining age 60. Benefits to a surviving spouse which are ended due to remarriage prior to attainment of age 60 should be reinstated on termination of that subsequent marriage, provided that any lump sum paid when the original annuity ended is returned. In either case, if termination of the subsequent marriage results in entitlement to a second survivor benefit under a Federal staff system based upon that subsequent marriage, the spouse should have the right to elect whichever benefit is more advantageous, but in any case no more than one.

Cost estimate

CSR: Cost of \$14.1 million annually.

FSR: Savings of \$260,000 annually.

Discussion

Survivor benefit programs under Federal staff retirement systems should function in accordance with their essential objective of providing benefits where death occasions loss of support. Those for Federal civilian employees should operate in consonance with the Cabinet Committee recommendation to provide benefit amounts which, in combination with any social security benefit that may be available to them, are at least equivalent to those which would be payable if the deceased employee's service had been covered under the Social Security Act.

Civil service survivor benefits for a spouse now terminate upon death, or upon remarriage, regardless of age. Reinstatement after remarriage may be authorized

in the event of annulment of the subsequent marriage, but not where divorce or death ends that subsequent marriage. The Cabinet Committee believes that the merits of reinstatement following death or divorce are equally as great as those following annulment. The need for reinstatement of entitlements in these circumstances is particularly compelling since most of the affected persons are women, who have spent most of their lives in marriages which terminate when they are far along in years, who have not been able to work to earn some benefit entitlement in their own right, and who are not able to begin work to provide for their own support. Further, the Committee believes, for essentially the same reasons, that persons receiving survivor benefits who have already attained age 60 at the time they remarry should not suffer termination of those benefits in the first place. Individuals at that age find it difficult to begin work to offset the loss of their survivor annuity. Additionally, their new spouse will normally be similarly advanced in years, perhaps in or approaching retirement with the attendant reduced income, and equally unable to undertake new or increased work to provide for a new dependent. Lastly, the liberalized treatment of CSR survivor benefits recommended here is basically in consonance with the 1965 amendments to the Social Security Act.

Foreign Service survivor benefits do not now terminate upon remarriage. The Cabinet Committee recommends that entitlements under both systems should be equalized. Those recommended above for application to a surviving spouse who remarries should apply to FSR as well. Such equalization should apply to those acquiring benefit entitlements in the future under the Foreign Service system, and should not operate to disturb existing entitlements in any way, including the existing entitlement of those already receiving spouse survivor benefits to remarry without suffering termination of same.

No surviving spouse affected by the foregoing provisions should concurrently receive two survivor annuities under Federal staff retirement systems, based on the death of two different deceased members (for this purpose, an annuity paid under the Social Security Act is not considered to be a benefit payable under any Federal staff retirement system). If death of the second spouse does result in entitlement to a second survivor benefit under a Federal staff retirement system based upon the second marriage, the surviving spouse should have the right to elect whichever benefit is more advantageous, but in any case no more than one.

A. 6. FEDERAL EMPLOYEES' GROUP LIFE INSURANCE

Recommendation

Maximum salary base for life insurance coverage should be raised from the present \$20,000 to executive salary level II. Subject to maintaining the existing 2-to-1 ratio for sharing of costs, the Civil Service Commission should be given authority to adjust contribution rates as necessary to meet the Commission's estimated level premium cost.

Cost estimate

Eleven million dollars annually, assuming rates are raised to improve financing. (\$120,000 of this is attributable to raising the maximum salary base.)

Discussion

An employee covered by the Insurance Act has group life insurance and accidental death and dismemberment insurance, each in an amount equal to (a) his annual basic salary rate (if such rate is a multiple of \$1,000) or (b) the next higher thousand dollars (where pay rate is not an even \$1,000 multiple), but not to exceed \$20,000. For each \$1,000 of life insurance coverage he pays 25 cents biweekly while the Government contributes 12½ cents, the existing statutory maximum.

Existing maximum coverage amount of \$20,000, selected when the program was established in 1954, was realistic in terms of top Government salaries at the time, and consistent with the \$20,000 limit on group life insurance then prescribed by statute in some States and the District of Columbia. Both of these factors have since changed. Top Federal salaries now range to \$35,000 annually, while the District of Columbia and about half the States have adopted a model law allowing group insurance above \$20,000 provided it does not exceed the lesser of \$40,000 or 150 percent of annual salary. The \$20,000 life insurance ceiling for Federal executives has now become unrealistic and discriminatory. The Committee proposes that the ceiling be based on and adjusted automatically with the salary assigned by law to executive salary level II (currently \$30,000).

Actuarial valuation of the insurance program shows the existing total biweekly premium rate of 37½ cents for each \$1,000 of insurance to be approximately 7

cents short of the level premium needed to adequately finance the insurance program as amended to date. This problem will become more acute as time passes unless steps are taken to strengthen the program's financial structure. Administratively, the most feasible and lasting solution would be to amend the Insurance Act so as to give CSC the authority to adjust contribution rates as necessary to meet the Commission's estimated level premium cost, subject to maintaining the existing 2-to-1 ratio for sharing costs as between employees and Government.

Numerous other suggestions for change in the life insurance program have been advanced to the Committee and have been given careful review. In the context of the total fringe benefits package for Federal workers, particularly with the various liberalizing provisions recommended in this report, the Committee has concluded that further change in the insurance program would be unjustified beyond the two proposals described above.

A. 7. MERGER OF OTHER RETIREMENT SYSTEMS WITH CSR

Recommendation

The Civil Service Commission should explore with officials administering the smaller contributory staff retirement systems the possibility of merging those systems with the civil service retirement system and, with concurrence of the administrators concerned, initiate action for such mergers as are deemed practical and desirable.

Cost estimate

No cost at this stage; probable longrun savings in administrative costs to the extent that mergers are accomplished.

Discussion

There are three basic Federal staff retirement systems—CSR, FSR, and MSR. CSR covers an estimated 2,300,000 civilian employees of the United States and District of Columbia governments. About 200,000 additional civilian employees, mostly temporary appointees, are covered by the social security system rather than a Federal staff retirement system. FSR now covers about 4,500 employees and a bill is now before the Congress that would ultimately triple this coverage. (H.R. 6277, as passed by the House on September 9, 1965, would result in the ultimate transfer of some 7,000 employees in the foreign affairs agencies from CSR to FSR.) MSR covers the 2,700,000 members of the uniformed services, they are also subject to the social security system.

In addition to the three basic plans, there are a few small civilian contributory retirement plans administered by the respective employing agencies listed below. All have additional employees who are subject to CSR.

<i>Plan</i>	<i>Approximate coverage</i>
Tennessee Valley Authority.....	11, 250
District of Columbia policemen and firemen.....	4, 300
District of Columbia schoolteachers.....	3, 900
Board of Governors, Federal Reserve System.....	570
District of Columbia judges.....	20
Central Intelligence Agency.....	Undisclosed

We believe, as did the former Committee on Retirement Policy for Federal Personnel, that inclusion of all regular civilian employees in a single retirement system (though not necessarily under identical retirement provisions) is a highly desirable goal and would contribute to better and more economical administration, maximum across-the-board consistency, and better coordination with other fringe benefits, CSR, which already covers about 90 percent of all civilian employees of Government and is administered by CSC in conjunction with other fringe benefit programs, is the only logical spot for consolidation. Most of the contributory systems are quite similar to it, and the differences that do exist are so slight that merger should be possible with minimum adjustment. Though merger may not be practical in all cases, the possibilities should be fully explored.

MSR and FSR are management oriented to a greater degree than is CSR. Both are closely coordinated with their respective personnel systems to facilitate the retention and promotion of the most able and to separate or retire the least able as well as those no longer able to fully meet requirements of the service. The close coordination between these retirement systems and their respective personnel systems is a basic reason for their continued separate existence.

Benefits of all systems should be consistent. We believe that CSR benefits should continue to be the standard against which benefits of other civilian retire-

ment systems should be measured. Adoption of other recommendations in this report will move substantially in the direction of standardizing benefits. Future changes should continue to move in this direction to the extent possible within the special management requirements of each service. Adoption of the Committee's first recommendation, which concerns the control of fringe benefit costs, will help achieve this objective.

A. 8. DISABILITY RETIREMENT

(a) *Earlier separation of disability retirees*

(b) *Leave system*

(c) *Optional versus disability retirement*

Recommendation

An employee under the civil service or Foreign Service retirement system who is retired for disability or who elects to retire optionally because he is unable to return to work on account of illness should be separated immediately upon approval of his application and should be paid for any unused sick leave to his credit with a temporary annuity supplement in an amount equaling the difference between the employee's retirement annuity and the salary that he would have earned had he remained in pay status for the time represented by his unused sick leave.

The Civil Service Commission should submit its conclusions and recommendations for improving the Government's leave system as promptly as possible.

When an employee is eligible for optional retirement with annuity, health, and life insurance coverage and Federal income tax treatment equivalent to that he would have as a disability retiree, he should not be considered for disability retirement. The agency's right to recommend the disability retirement of such an employee should not, however, be restricted.

Cost and savings estimate

(a) CSR cost of \$5.8 million annually to retirement fund in earlier payment of annuities; savings of \$7.5 million annually in payroll expenditures by agencies. FSR cost of \$11,600 annually; annual payroll savings of \$15,000.

(b) Not applicable.

(c) Savings of \$50,000 annually in the costs of processing retirement claims.

Discussion

The committee is concerned that such a large proportion of applications for retirement are filed for disability. Disability retirements increase the costs of administering the system. Sick leave used in connection with disability retirement is creating acute difficulties for Federal agencies. A number of possible ways of reducing the disability work load were explored. The sick leave problem was also studied.

An employee having to retire because of ill health is properly entitled to the protection provided by his sick leave. On the other hand, extensive use of sick leave by employees planning to retire cannot be allowed to interfere with the effective and economical fulfillment of agency missions. With the approval of an employee's retirement application there is no reason for continuing to carry him on the agency payroll. He should be separated immediately and paid for any unused sick leave remaining to his credit. The amount of the payment should be the difference between the employee's retirement benefit and the income from salary that he would have received had he remained in pay status until the sick leave was used up. The payment should be made by the agency with funds now used to pay for sick leave.

The Committee recognizes the danger of tampering with the leave system on a piecemeal basis. With the adoption of the proposal referred to above, the Committee would urge CSC to submit its conclusions and recommendations for improving the leave system.

Of several plans considered, the most promising way to curb retirements for disability would be to deny the disability option to employees who, by their age and service, qualify for optional retirement with the same Federal Government benefits. Under such a provision there would be no assurance that retirement for disability would not still be to an employee's advantage. In some States, for example, disability retirees are eligible for unemployment compensation, and some employees have private insurance policies which waive premiums in the case of disability. The protection of these benefits, however, does not appear to be a reasonable obligation for the Government, as an employer, to assume. If the

employee is eligible for optional retirement with full Federal Government benefits, the Committee believes that he should not be allowed to file for the disability annuity.

A. 9. TAX TREATMENT OF RETIREMENT BENEFITS

Recommendation

An intensive study should be undertaken by the Secretary of the Treasury, with participation and review by the other Federal departments and agencies, for the purpose of conducting a comparative analysis of the income tax treatment accorded to individuals receiving various benefit payments under the several Federal staff retirement systems. The Committee recommends that priority in conducting this analysis be accorded to consideration of the principle of extending tax treatment to Federal annuitants not now covered by the Social Security Act equivalent to that accorded recipients of old-age, survivors, and disability insurance benefits.

Discussion

More than 9 out of 10 people in paid employment and self-employment in the United States are covered or eligible for coverage under the old-age, survivors, and disability insurance (OASDI) provisions of the Social Security Act. More than 2 million Federal civilian employees covered under a Federal staff retirement system constitute one of the largest single groups not covered under OASDI.

The Cabinet Committee has recommended establishment of a system to provide benefits at least equivalent to those payable under the Social Security Act for persons having benefit entitlements under Federal staff retirement systems covering civilian employees. However, the tax treatment of many Government employees whose Federal employment is not covered by OASDI does not now equate with that afforded both Government and non-Government employees who are covered under social security. It would not equate under the Committee's recommended system, unless special income tax provisions were concurrently enacted. The fundamental reason is that all OASDI benefits are automatically excluded from gross income in computing individual income tax. Only that portion of the annuity received by Federal civilian employees from their respective staff retirement systems which constitutes a return of their own contributions is automatically excluded. In addition, a retirement income credit is available immediately to persons retiring under a public retirement system (Federal, State, etc.), while other retirees do not qualify for the credit until age 65. Some Federal annuitants are thus afforded a tax advantage not shared by persons covered under nonpublic retirement systems. Others, owing largely to the manner in which the retirement income credit is computed, remain at a disadvantage compared to their counterparts in the private sector who are covered by OASDI.

In these circumstances, substantial equivalency in terms of individual income tax treatment might be attained by applying to Federal annuitants whose Federal service is not now covered under OASDI the same rules governing exclusions from gross income for Federal income tax purposes that would have applied on that portion of their annuity equivalent to the amount they would have received under OASDI if the service on which the annuity is based had been covered under the Social Security Act. Extension of this tax entitlement might also effectively contribute to fuller implementation of the above-discussed recommendation by the Cabinet Committee designed to assure benefit payments under Federal staff retirement systems for civilian employees which are at least equivalent to OASDI.

The Committee recognizes, however, that the issues just discussed cannot properly be considered in isolation. For example, there are significant differences in the tax treatment of disability benefits paid under the several staff systems. In important respects, these differences are closely interwoven with those discussed above. Further, the Committee has not been unmindful of the rationale underlying fundamental distinctions in the taxable status of payments received under a given Federal staff retirement system, as opposed to another. These distinctions require evaluation in the light of the duties performed by the members concerned, as well as their job environment. The impediments to a precise comparative analysis of tax treatment under the several Federal staff systems may be largely the result of overlapping entitlements designed to meet the special and complex needs of the service and the employee, as they exist from one department or agency to another. Finally, it is imperative that any comprehensive analysis be conducted with due regard to the technical aspects of existing tax law and the impact in the private sector of any changes which might be proposed.

The Committee believes that in these circumstances both the Government and its employees might benefit, and the purposes for which the Committee was organized might be better attained, if a more exhaustive analysis of this subject

were conducted on an impartial basis by qualified specialists. Such analysis should be undertaken by the Secretary of the Treasury, with participation and review by other interested Federal departments and agencies.

A. 10. VOLUNTARY CONTRIBUTIONS

Recommendation

Provision for purchasing additional annuity through voluntary contributions to the civil service and Foreign Service retirement and disability funds should be discontinued, in view of its relative disuse, without jeopardy to contributions made before enactment date of the change.

Savings estimate

Annual administrative expense of CSC of \$13,000, plus negligible administrative expense saved in both the Treasury Department and FSR.

Discussion

Employees who do not owe deposit or redeposit moneys may make contributions to the CSR fund, over and above regular salary withholdings, for the purpose of obtaining additional annuity at retirement. Contributions to the fund earn interest at 3 percent. Each \$100 credited to an employee's voluntary contribution account purchases \$7 if he retires at age 55 or younger, with a 20-cent increase for each year he is beyond age 55 at retirement. The formula produces bargain rates as low as 74 percent of actuarial value for women and 80 percent for men. The ultimate advantage of voluntary contributions, to any one individual, depends on the number of years over which the additional annuity purchased by the contributions will be paid.

The employee may withdraw the sum credited to his voluntary contribution account at any time before receipt of any additional annuity based thereon. An individual may defer the deposit until retirement, in the meantime investing his money where it will earn more than the 3 percent provided by the fund.

The CSR voluntary contribution plan attracts the interest of only one-seventh of 1 percent of eligible employees. Participation has declined over the years; e.g., there were 6,650 accounts on June 30, 1951, and only 3,328 accounts on June 30, 1965. In fiscal year 1965 new accounts totaled 384, whereas 577 accounts were closed. Balance in the fund at June 30, 1965, totaled \$9,745,136.01. Contributions in fiscal year 1965 totaled \$2,003,307.

The FSR plan, which is substantially similar, has attracted less than seven-tenths of 1 percent participation. There are about 30 active accounts and approximately 890 accounts in all, with total deposits slightly in excess of \$375,000. Many of these accounts were transferred with the employees from CSR to FSR.

The voluntary contribution plans have the effect of providing savings accounts or supplemental insurance to an insignificant number of employees. Voluntary contribution plans are not an essential part of the retirement systems, which base the annuities on length of service and level of basic salary. The administrative cost of their continuance is not justified by employee need, popular demand, or agency requirements. The voluntary contribution privilege should therefore be revoked, prospectively so as not to impair any rights or benefits already acquired.

A. 11. DEPOSITS FOR NONDEDUCTION CIVILIAN SERVICE, AND REDEPOSITS OF CONTRIBUTIONS WITHDRAWN

Recommendation

Under the civil service retirement system, failure to redeposit contributions withdrawn should be treated in the same way as failure to make deposits not withheld—that is, by crediting the service but applying the 10-percent reduction formula if payment is not made. Related provisions of the Foreign Service retirement system should be brought into full conformity with the civil service provisions.

Cost estimate

CSR: \$2 million annually.
FSR: Negligible.

Discussion

An employee subject to the CSR Act or his survivor must redeposit (with interest) any money refunded to him upon a prior separation before service covered by the refund may be credited in computing the employee's annuity. Such service is counted, however, in determining entitlement to annuity. Civilian service during which no retirement deductions were withheld from an employee's

salary is creditable with or without deposit; failure to make such a deposit results in the annuity otherwise due being reduced by 10 percent of the sum owed.

Authorization for crediting nondeduction service without deposit has been part of the CSR Act since 1938. The ostensible reason for not also crediting redeposit service (unless redeposit is made) is that the employee's withdrawal of compulsory contributions creates a deliberate indebtedness to the CSR fund which should be satisfied. The net effect is that the employee who cannot raise the necessary money for redeposit must accept a benefit reduction several times the actuarial value of such amount. This is inequitable. As a matter of uniformity and justice, credit for the service rendered should be given in both situations, applying the 10-percent reduction formula if payment is not made.

Under FSR, no credit is given for service for which a deposit or redeposit is owing, and such service does not count toward establishment of annuity title. Further, survivors of participants who die in service do not have the option to make deposits or redeposits. This is particularly significant with respect to survivors of FSR participants who die in service with less than 5 years of paid-up civilian service—the minimum required for survivor benefits—but with sufficient other civilian service for which a deposit or redeposit is owing so that total service equals 5 years or more.

The Committee finds no justification for this different and less favorable treatment of deposit and redeposit service under FSR and recommends that it be changed to accord with the treatment presently provided for deposit service under CSR and that proposed for redeposit service under CSR.

B. 1. AGE-SERVICE REQUIREMENTS

Recommendation

The retirement structure should be geared to the normal expectation of retirement at age 65, with opportunity for management to continue the older productive worker under the retirement system up to age 70, retention of existing authority to rehire annuitants at any age, and a broad range of employee options for early retirement with unreduced benefits.

(a) The high-five salary average should be determined from salaries earned prior to age 65 (except in the case of elected officials).

(b) Retention of employees after age 65 under the retirement system should be permitted on a year-to-year basis up to age 70 by affirmative management decision.

(c) Existing authority to reemploy annuitants at any age should be continued.

(d) Optional retirement with unreduced annuity should be permitted beginning at age 55 after 30 years of service, age 60 after 20 years of service, and (as at present) age 62 after 5 years of service.

As a conforming change, and to preserve flexibility in the employment of older people, persons appointed after age 65 should be given social security coverage rather than staff retirement coverage.

Cost estimate

Retirement at 65-5, selective retention to age 70—\$71 million annually.

Retirement at 55-30 and 60-20—\$23 million annually.

NOTE.—These are estimated costs to the retirement fund. Gains in productivity resulting from the recommended changes are expected to produce offsetting savings to the agencies.

Discussion

Present CSR provisions enable employees to retire beginning at age 55 after 30 years of service, but with a 1-percent reduction in annuity for each year the employee is under age 60 at time of retirement. Retirement with unreduced annuity is available at age 60 after 30 years' service and at age 62 after 5 years' service. Retirement is mandatory at age 70 after 15 years of service; the annuitant may, however, be rehired on a temporary renewable basis.

In industry, age 65 is quite generally the normal retirement age, although there is some trend to age 62 or 60. Frequently, normal retirement age is also the compulsory retirement age. In many cases, retirement credit is not given for any service performed after the normal retirement date. The annuity reduction for voluntary retirement before age 65 or 60 is usually very substantial.

Thus the CSR provisions for age-and-service retirement are on the whole more liberal and flexible than the corresponding features of most private pension plans, notwithstanding recent liberalizations in basic steel, automotive, and several other industries. There are, however, certain deficiencies in CSR. Improve-

ments are recommended to give more realistic recognition to the needs and capacities of individual workers, and to make the retirement system more responsive to operating requirements. The anticipated net result will be a material overall improvement in Government efficiency, more than offsetting the added costs to the retirement fund.

The chief problem with the existing structure is that many workers stay on active duty rolls beyond their period of real effectiveness, and that certain present provisions of the system lend encouragement to that tendency. The Government is firmly committed to a policy which prohibits discrimination against older Americans in Federal employment and which judges employees on the basis of ability rather than age. It is widely recognized that individuals age at different rates. The retirement structure, however, does not provide the Federal employing agency with an adequate means of distinguishing between those who should retire and those of the same chronological age who are still fully productive.

Part of the problem is that the high-5 average is not static, but is periodically enriched by general pay increases. This exerts a strong pull upon employees to stay on the rolls, irrespective of performance level, so as to gain the greater retirement annuities to be derived from the growing salary base. This has been a particular attraction since the civilian pay structure has been pegged to private industry pay rates under the pay comparability principle, enacted in 1962. During the past 5 years, CSR basic annuity values for current employees have risen by as much as 20 percent or more due to general pay increases.

A further aspect of the problem is that the 15-year service minimum in mandatory retirement not only prolongs the employment of some who should retire but deters the hiring of new workers who would not have the 15 years of service by the time they reach age 70. This provision was adopted in 1926, when there were few private pension plans and no social security program. Older hires had a genuine economic need to gain a significant CSR benefit, even if this took their Federal employment well past age 80. Today, the older person with short Federal service may be presumed to have other public or private pension coverage: some 90 percent of the Nation's labor force are covered by social security, and about one-third of the labor force by private pension plans. Reduction of this 15-year service minimum to 5 years would improve Government efficiency, help greatly to overcome reluctance of agencies to hire qualified older workers, and bring about consistency with the 5-year minimum service provision for disability, deferred, and voluntary age 62 retirements.

It is proposed that age 65 be accepted as the customary time for normal retirement, toward which employees may orient their personal plans. The CSR Act should be amended accordingly to provide for the orderly and timely release of employees upon reaching age 65 after at least 5 years of civilian service and (except for elective officials) to provide for the determination of high-5 average on the basis of pay received prior to age 65. In recognition of individual differences in aging and productive capacity, agency management should be authorized to retain employees on a selective basis for year-to-year employment under the retirement system up to age 70. (Years-of-service credit for such continued employment would be given in the computation of the employee's ultimate retirement annuity.) Present authority to reemploy annuitants at any age should be retained.

Realistic acknowledgment of age 65 as the normal retirement objective of employees will bring the CSR structure into better alinement with general industry practice, with the social security retirement age, and with other Federal staff retirement systems. The retention authority, which it is anticipated will be liberally exercised, will give increased emphasis to the utilization of the older productive worker.

To supplement and reinforce the proposed provision for normal retirement at age 65, it is necessary that persons newly appointed after age 65 be given year-to-year renewable appointments. This would automatically place their appointments under social security rather than under CSR. It puts the same limitation on their tenure that is proposed for employees who are continued under the retirement system past age 65 by management selection. And it removes the familiar retirement barrier to their possible employment.

Federal employee organizations are particularly interested in further liberalization of the provisions for voluntary retirement before normal retirement age. The committee observes merit in the argument that retirement at age 55 after 30 years' service, with unreduced annuity, would make it more feasible economically for workers with partial disability, declining capacity or interest, or obsolescent skills to withdraw from active service. From the employer's standpoint, 55-30 retirement with unreduced annuity would have another and less desirable effect

in that it would give other employees an incentive to withdraw at the peak of their usefulness to the Government and take other employment. This disadvantage could be offset if a limited two-way retirement option were authorized (as recommended elsewhere in this report), whereby agency management as well as employees could exercise the retirement option in the case of high-level employees who are age 55 or more and have at least 30 years of service. On condition that such a two-way option is authorized, the committee anticipates an overall benefit to the Government in permitting retirement at 55-30 with unreduced annuity and recommends its adoption. In earlier (involuntary separation) retirements where annuity reduction for age is required, the reduction would be computed from age 55 rather than from age 60.

Retirement at age 60 after 20 years of service would furnish a logical intermediate option between 55-30 and 62-5 retirement. It would give a new option to employees at an age when they may reasonably feel entitled to stop work or cut back to partial employment, or when it may be a physical necessity to do so. As an integral part of the proposal for liberalizing the 55-30 provision and authorizing a two-way option, the committee recommends 60-20 retirement in lieu of the present 60-30 provision.

The committee has reviewed a number of other suggestions in the area of early retirement, including (1) retirement with unreduced annuity after 30 years of service at any age, (2) lower age-service requirements for involuntary separation retirement (now permitted after 25 years of service, or age 50 with 20 years' service), (3) more restrictive application of the involuntary separation retirement provisions, and (4) modification of the preferential early retirement provisions now applicable only to certain law enforcement personnel so as to permit the coverage of other groups, such as air traffic controllers, and provide a guaranteed minimum annuity of 50 percent of the employee's high-5 average.

To a major extent the recommendations in this report will accommodate the purposes underlying those various suggestions. In addition, the problem has been met in significant part by the recently enacted severance pay provision for employees who are involuntarily separated before gaining eligibility for immediate retirement. Still further liberalizations in early retirement would not be justified, in the committee's view. At the very early ages which have been suggested for retirement eligibility, it is evident that the affected employees will not in fact retire from work, and it would be more realistic to direct further attention to exploring the opportunities for retaining them in Federal employment.

The committee has also considered the feasibility of recommending changes in the annuity computation formula. Under the general formula a percentage of average salary during the highest 5 consecutive years of earnings is multiplied by years of service, as follows: $1\frac{1}{2}$ percent times the first 5 years of service, $1\frac{3}{4}$ percent times the next 5 years of service, and 2 percent times any remaining years. The results are then added to produce the basic annuity. It has been urged that the $1\frac{1}{2}$ - or $1\frac{3}{4}$ -percent factor, or both, be changed to 2 percent, and that the wage base be changed from high-5 to high-3, high-2, last full year of employment, or career average.

The committee has concluded that the very substantial added cost of any of the changes in the percentage multiplier would be wholly unwarranted. Estimated increased cost (normal plus interest) of a straight 2-percent multiplier would exceed \$200 million annually. Computation of average salary on the basis of a period shorter than 5 years would strengthen rather than reduce the incentive for employees to stay in active service beyond the time they otherwise would retire, in that the salary averages would then be even more immediately responsive to changes in current pay. On the other hand, substitution of a career average would sharply depress the annuities of long-term employees unless the percentage multiplier were substantially increased and that, in turn, would raise the annuities of short-termers more than is justified by their service. The committee has accordingly rejected each of the several alternatives for changing the annuity computation formula.

B. 2. AGENCY DISCRETION TO RETIRE CERTAIN ELIGIBLE EMPLOYEES

Recommendation

Agencies should be authorized to retire, at management's discretion, employees at GS-13 (or its equivalent) and above who are eligible for retirement on immediate annuity and who have 30 years of service.

Discussion

The single most urgently needed change in CSR, from an operating standpoint, is management authority to retire employees on a selective basis.

Employees do not age uniformly, nor sustain productive capacity evenly, and the retirement system provides management no effective means of dealing with such individual differences. Management has a meaningful role in most personnel processes, including selection, placement, and pay, but little or no role in deciding which employees are to retire and at what time. The only true options are vested in the employee. (Management can request disability retirement, but the decision is made by CSC on medical grounds.)

Even though a particular employee's skills may no longer be greatly needed by his agency; even though partial disability or other factors may prevent him from maintaining the full pace called for by the job; even though his retirement would prevent the RIF-ing, or permit the appointment or promotion, of someone else who could contribute more to the efficiency and productivity of current agency programs, the agency cannot retire him. This is true even of those who are eligible for retirement with full benefits. Management has neither the justification nor, even less, the desire, considering their many years of service, to remove most such employees on charges. Yet failure of many of these employees to exercise their retirement option seriously impedes management efforts to achieve constructive change, increase productivity, and speed progress on agency programs. In the interest of good government, some way must be found to make the retirement system more responsive to legitimate institutional needs. Continued one-way employee option is not the answer, especially in the case of higher level administrative and executive employees whose unrealistic judgment of their continued value to the agency has far-reaching repercussions throughout the organization. The committee understands the unwillingness of employee organization spokesmen to accept unrestricted agency option to retire employees. Yet agency option subject to procedural safeguards is not the answer; the procedures effectively prevent use of the option, as was clearly demonstrated by experience between 1942 and 1948.

The problem can be eased, however, by making the retirement option two way for those who, because of the level of the positions they occupy, most importantly affect agencies' operations. The committee therefore recommends that the retirement option be made a two-way one for employees at GS-13 (or equivalent) and above who have attained age 55 and who have 30 years or more of service. Within this range, either management or employees should be able to exercise the option without burdensome procedural requirements or appeal rights on either side.

This proposal does not fully meet management needs but does provide a reasonable middle ground for reconciling management and employee interests. At the levels where management's need is most critical, it gives management a right approaching, if not equaling, that long given to employees. It protects all employees who are subject to the proposal against retirement with service too short to produce reasonable annuities. The proposal also assures all employees continued opportunity to retire in dignity and with the undiminished respect of their peers, for under a two-way option no employee need be in the position, unless he so chooses, of allowing management to exercise the formal option. Retirement on unredacted annuities at 55-30 and 60-20 would, if approved, be compensating benefits.

Granting management some measure of authority to initiate retirement of civil service employees on a selective basis moves in the direction of uniformity, since both the Foreign Service and the military service already have such authority on a much broader basis. It is also consistent with recent trends in union-negotiated pension plans in private industry.

B. 3. GUARANTEED MINIMUM SURVIVOR ANNUITY

Recommendation

The formula for a guaranteed minimum annuity now applied to disability retirements should be authorized as a base for computing the benefits of widows and widowers who are eligible upon the death of an employee in active service or after retirement for disability, as in the Foreign Service retirement system.

Cost estimate

Annually, \$26.5 million.

Discussion

Short service earns small annuities under CSR. When an employee with short service retires for age, he usually has additional benefits earned in other employment. When an employee with short service retires for disability, he is guaranteed a minimum benefit: he receives an annuity based either on his service

(unreduced for age) or the lesser of (a) 40 percent of his high-5 average (equal to credit earned by 21 years and 11 months of service) or (b) the amount based on the general formula with his service credit increased by the number of years between his age when separated and age 60.

An employee retired for disability has the option of providing a benefit for his widow or widower in case of his death, but the survivor's benefit can be based only on the amount of annuity earned by service; the guarantee of a minimum benefit cannot extend to his survivor. Likewise, when an employee dies in service, his survivor's annuity is based only on service, without the protection of the guaranteed minimum. Present provisions of CSR fail to provide adequately for the survivors of younger employees in particular. Survivors under FSR have the protection of the minimum annuity guarantee.

It is proposed that the guaranteed minimum be applied in computing survivor benefits when an employee dies in service and also when a disability annuitant dies unless he specified at the time he retired that the survivor annuity be waived or based on only a portion of his annuity. In this manner, the survivor's protection is improved and CSR becomes consistent with FSR.

The social security minimum previously recommended for CSR and FSR (and implicit in MSR) will be applicable in a large number of these cases. However, this additional provision affords better protection for survivors of higher salaried employees, particularly young professional personnel.

B. 4. DISABILITY RETIREMENT

(a) *Annuitants restored to earning capacity*

Recommendation

Disability benefits payable to an annuitant whose earning power is restored should be discontinued at the end of his second consecutive year of 80 percent earnings.

Savings estimate

In benefit payments, \$0.2 million annually.

Discussion

If a disability annuitant's earnings in each of 2 consecutive years amount to 80 percent or more of the current salary of the Federal position he last held, he is dropped from the annuity roll at the end of the following year. This is done to prevent payment of annuities to "disabled" persons who actually are gainfully employed.

Since 1956, over 1,200 annuitants have been dropped from the disability roll because their earnings exceeded the limitation. In each case, payment of the annuity was continued for at least a year after the end of the annuitant's second year of 80 percent earnings. The cost to the retirement system represented by the last year's payment was unnecessary.

The procedure is also discriminatory. Upon reemployment by the Government a disability annuitant is dropped immediately from the retirement roll. On the other hand, an annuitant who finds employment in the private sector may work for up to 3 years, regardless of earnings, while he continues to receive his annuity benefit. Elimination of the last year's annuity payments will more nearly equate treatment of restored-to-earning-capacity annuitants with those who return to work for Government.

(b) *Reinstatement of life insurance and health insurance benefits*

Recommendation

An annuitant who is dropped from the disability roll under an earnings test or because of a medical examination showing recovery should be allowed to resume his group life insurance and health benefits eligibility if his disability annuity is later reinstated.

Cost estimate

Negligible cost.

Discussion

A disabled employee is eligible to continue his group life insurance coverage and his enrollment under the health benefits program after retirement. If he either recovers from his disability or finds other employment and has to be dropped from the retirement roll, his life insurance and health insurance are discontinued. If the disability subsequently recurs, he becomes eligible for

reinstatement on the disability roll, but the life insurance and health benefits coverage are not resumed.

A recovered disability annuitant who does not return to work for Government should generally be accorded the same treatment as any other separated employee. If his earning capacity is again impaired by the same disablement, however, payment of the disability benefit will be resumed. The reinstatement provision is based on the principle that the Government has a contingent responsibility for the welfare of a recovered disability annuitant. The same principle can be extended to support the idea that an annuitant should be allowed to resume other benefits that were terminated when the annuity was discontinued.

Adoption of this proposal should serve a worthwhile social purpose because a disability annuitant will have less to lose potentially by returning to work. Some annuitants may be dissuaded from looking for work because of the possible loss of benefits under the present procedure.

B. 5. SURVIVORS' BENEFITS—DEPENDENCY REQUIREMENT

Recommendation

The civil service retirement system should pay benefits to otherwise eligible children of employees dying in active service or after retirement, whether or not the children received more than half their support from the deceased parent.

Cost estimate

There is insufficient information available on which to base a cost estimate, but it is believed to be negligible.

Discussion

Under CSR, when an employee dies (whether before or after retirement) leaving a widow or widower with children, children receive benefits only if they received more than one-half their support from the employee-parent who died. The parent who had the larger income is presumed to have provided the major support unless the contrary is clearly shown. The effect is that benefits are almost always paid when the father dies, and only rarely if a working mother dies.

Retirement systems are intended to cushion the effects of loss of income through death, among other things. The provision on children departs from this principle and runs counter to the facts of family life. The 1960 census showed that the preponderance of working wives are in lower income families with children aged 6 to 17. They work because the family needs the money, especially for the children. At the same time, the wives' earnings are secondary in family support. Eighty percent of working wives contributed less than 40 percent of the family income. In short, the income of working mothers is particularly significant for the support of children, but it is inadequate to meet the children's dependency requirement when the mother dies.

If the mother is an annuitant, the same considerations apply, with perhaps greater force because annuitants' family incomes are generally lower than employees'. Relatively few children remain eligible in terms of age when annuitants die, except for children of men and women retired for disability and children who receive benefits past normal age because they are themselves disabled.

Stepchildren and natural children are eligible for benefits at present only when they have been dependent on the deceased parent and living with the parent in a regular parent-child relationship. The latter requirement should be retained; but, if it is fulfilled, the benefits should be paid as for any other child, without regard to the dependency requirement.

This issue is academic under MSR and FSR because few members are working mothers. In any event, the systems have no significant dependency requirements for children except those attached to OASDI; and, if OASDI rules a child of a military member ineligible for benefits, the VA pays him under dependency and indemnity compensation.

It has been proposed that widowers be placed on an equal footing with widows. At present, widows' benefits are paid automatically, but in all systems widowers must be dependent and incapable of self-support because of disability. It is asserted that this discrimination is improper, because both husband and wife contribute to family support, and both pay at the same rate for membership in the systems. The proposal has been rejected in favor of the recommendation made above. Payment of benefits for children on death of the working mother is justified by general family necessities; but payment of benefits largely from public funds for males with no eligible children and capable of self-support is unacceptable. The wife's contributions are refunded. Additional expenditure would burden the systems with unnecessary costs.

B. 6. SERVICE CREDIT

(a) *CSR credit for non-Federal employment**Recommendation*

Civil service retirement credit should be granted only for service which meets the clear general criteria presently established for that purpose. Proposals which would broaden those criteria, or authorize exceptions to them, to credit service performed by State or State-instrumentality employees in programs supported wholly or partly by Federal funds should be disapproved.

Discussion

An individual's service must have been performed as a Federal employee to be creditable under the CSR Act. To be considered a Federal employee, a person must be engaged in the performance of Federal functions under authority of an act of Congress or an Executive order. He must be appointed or employed by a Federal officer in his official capacity as such. He must be under the supervision and direction of a Federal officer. CSC has accorded these criteria a liberal construction in applying them as tests of Federal employee status. The courts have generally held this test and the established criteria to have a reasonable basis in law.

The executive branch has consistently proposed enactment of legislation designed to broaden the established Federal criteria, or make exceptions to them, to include employees of State programs supported in whole or in part by Federal funds. While a precise estimate of the number of persons who would be affected by such legislation is not available, that number would be large and very substantial retirement costs would be imposed upon the taxpayer. The Cabinet Committee does not believe that the arguments in favor of such legislation are compelling. Granting retirement credit to individuals who do not meet prescribed Federal employee criteria would constitute an improper use of Federal funds to cover persons who perform essentially State functions. It would result in a fundamentally unsound assumption by the Federal Government of State fiscal obligations. Precedents established by such action would inevitably lead to further broadening of creditable service categories, and the eventual complete degeneration of CSR as an effective instrument of Federal personnel management. In the process, substantial inequities among categories of employees would be generated.

In the Committee's view, the proper long-range approach to the State service issue lies in other areas, such as incorporation of vesting provisions in State retirement plans or establishment of social security coverage as the basic protection for all State and Federal employees, supplemented by annuities earned under Federal and State retirement systems. Retirement coverage could thus be guaranteed for each segment of the employee's working career, with costs borne by the employer for whom he worked, and unfettered transfer of employees between State and Federal service promoted to the advantage of government services generally.

(b) *Wartime service of Foreign Service local employees with neutral governments**Recommendation*

Any period of employment performed by an alien employee with a foreign government for the purpose of protecting or furthering the interests of the United States should be considered as service for purposes of the Civil Service Retirement Act provided such employment occurs during an interruption of diplomatic relations requiring the evacuation of the U.S. diplomatic mission or consular post from the jurisdiction where such employment is performed and for which reimbursement is made by the U.S. Government provided further that the employee otherwise completes at least 5 years of civilian government service during which he is subject to the civil service retirement system. Such credit should be granted irrespective of whether the employee is initially hired by the Foreign Service (the usual case) or by a neutral government. Any employer contributions to the civil service retirement fund required by such employment should be paid from any moneys appropriated to the Department of State. The Secretary of State should maintain and certify to the Civil Service Commission such records as may be required by the Commission in each case. This recommendation should apply only to persons employed by the Federal Government or who perform subject service on or after the date of enactment.

Cost estimate

Estimated one-time cost—\$230,000 for presently affected employees. (Costs would be increased to the extent the provision is expanded to cover cases arising in the future.)

Discussion

Alien (local) employees of the Foreign Service working in a U.S. Embassy or consular post are separated from Federal service when diplomatic relations with the country exercising jurisdiction in the area involved are broken. Arrangements are made at such times to have a neutral power, frequently Switzerland, protect U.S. interests on a reimbursable basis. In such cases the neutral power usually hires some of the separated Foreign Service local employees to carry on the work involved in handling U.S. matters. The local employees are thereafter usually rehired by the Foreign Service upon resumption of diplomatic relations.

Service under such circumstances has not been creditable for civil service retirement purposes. This has been a problem since World War II during which several hundred Foreign Service local employees transferred to the Swiss in order to continue to serve U.S. interests in enemy and occupied countries. Also, during the course of the war, a few persons were hired by the Swiss to perform work for the United States that had not previously been employed by the Foreign Service. After the war, most returned or were appointed to Foreign Service rolls and about 150 are still so employed. In addition, 35 others are now employed by the Swiss in Cuba, helping to protect U.S. interests there.

The Department of State has requested that a way be found to grant CSR credit for such service in order to avoid penalizing those of its employees who find themselves in this unique circumstance. Employees with such service, and those around them, recognize that, although they have served the United States for many years, they are denied retirement credit for those years when, perhaps at some personal risk, they continued to serve the United States despite the enforced absence of their American employers. The Department of State reports that this unfortunate situation casts the United States in the role of an unfair and ungrateful employer and that this appearance is damaging to the United States in its foreign relations.

*(c) Civil service retirement credit for National Guard technicians**Recommendation*

Since National Guard technicians perform essentially Federal functions, necessary procedural changes should be effected by statute to provide formally for their Federal appointment and supervision. Their resulting formal designation by statute as Federal employees would entitle them to Civil Service Retirement Act credit and related Federal benefits. As Federal employees thus designated, they should concurrently be granted a statutory entitlement to civil service retirement credit for all past National Guard technician service.

<i>Annual cost estimate (assumes July 1, 1966, effective date):</i>		<i>Millions</i>
Level premium cost of extending CSR coverage.....		\$57.6
Deduct interest on incremental unfunded liability.....		-20.2
Normal cost.....		34.4
Deduct employee share of normal cost.....		-18.7
Annual DOD retirement cost.....		18.7
Annual cost of group health benefits.....		2.5
Annual cost of group life insurance.....		1.0
Subtotal.....		22.2
Deduct Federal contributions to State systems and social security under existing law.....		-13.7
Net annual DOD cost increase.....		8.5

Discussion

National Guard technicians constitute the full-time nucleus of key personnel assigned to Army and Air National Guard units of the several States, the District of Columbia, and Puerto Rico. They normally must have federally recognized National Guard status to qualify for technician appointment, and usually have concurrent status in the Ready Reserve components of the Army or Air Force. They are employed for the fundamental purpose of maintaining property of the United States for the use of the National Guard. Their numbers and authorized

compensation are fixed by the Federal Government, and they are paid directly on Federal payrolls by U.S. finance officers from federally appropriated funds at levels comparable to Federal employees performing like work. Employer contributions of up to 6½ percent of individual compensation are authorized by Federal statute and paid from federally appropriated funds for social security and/or State retirement coverage, where such coverage is authorized by individual States. The entire technician program serves the fundamental purpose of providing a constantly ready force capable of responding immediately to meet military requirements.

Though performing essentially Federal functions, technicians are not formally appointed by Federal officers. Though their duties and the functions of the organizations to which they are assigned are generally prescribed by Federal regulations, they nominally are under the immediate supervision of State rather than Federal officers. For these reasons they do not now formally qualify as Federal employees under prescribed criteria, and are thus denied Federal CSR benefits. In a majority of the States, they are also denied State retirement system coverage on the ground that the States do not fix their number, their compensation, their conditions of employment, nor appropriate the funds to pay them, or even participate in the salary payment process since disbursement is made direct to technicians by the Federal Government.

National Guard technicians should not be thus left in a legal no man's land, bereft in many cases of retirement coverage. The basic national security mission they are employed to perform clearly warrants enactment of legislation formally designating them as Federal employees for all purposes. Such action would not compromise existing distinctions between Federal and State service in determining creditability of such service under the CSR Act. Rather, it would formally recognize by statute the essentially Federal employment in which technicians are now and have been engaged, thus allowing them a just entitlement to CSR credit for the essentially Federal services they have in the past and will in the future perform.

B. 7. REEMPLOYMENT OF ANNUITANTS

Recommendation

Reemployed annuitants should be allowed full salary plus annuity for up to 720 hours a year (any consecutive 12-month period), with salary reduced by the amount of the annuity during the remainder of the year, provided that the combined annuity and salary received during the year should not exceed the highest per annum rate at which the annuitant is employed within the 12-month period.

Cost estimate

No additional cost to the CSR fund. Agency costs not computed.

Discussion

The general rule for pay treatment of reemployed CSR annuitants is that the annuity payments continue, salary is reduced by the amount of the annuity, and the employee earns neither retirement nor social security credits. This general rule applies to age retirees, annuitants who left the service voluntarily, persons dismissed due to misconduct or delinquency, and disability annuitants not found recovered or restored to earning capacity. One other category of reemployed annuitant continues to receive his annuity, with salary reduced by the amount of the annuity, but does earn social security credits. This is the retiree who was separated involuntarily (not for age, misconduct, or delinquency) and is reemployed in a position not having retirement coverage.

Separate pay treatment is accorded to reemployed disability retirees who are medically recovered or whose earning capacity is restored, and to retirees who were involuntarily separated (not for age, misconduct, or delinquency) and are reemployed in positions having retirement coverage. In such cases the annuity terminates; the employee receives the full salary of the position and earns social security or additional retirement credits, depending on the system under which his reemployed position is covered.

In addition, the reemployed annuitant whose annuity payments continue may receive supplemental annuity based on the reemployment service if it is on a full-time basis for at least 1 year, and the annuity may be recomputed if the full-time reemployment continues for as long as 5 years.

Present restrictions unduly discourage most retirees from returning to Government even for limited assignments. The experience and ability of many of these people are needed on occasion, especially persons who retired optionally or for age. Examples include the retired postal employee, who would be invaluable for peak

period and possibly weekend duty, and the high-level specialist who may be needed intermittently as a consultant or for a one-time project. An annuitant interested in further employment might well prefer to work outside the Government without penalty; i.e., continuing to receive full annuity plus undiminished salary and possibly social security credits as well.

More favorable treatment is accorded to persons retired from other retirement systems upon taking employment in the Federal civil service, including military retirees, retired District of Columbia policemen and firemen, reemployed Foreign Service annuitants, and all persons drawing benefits from non-Federal systems. A significant number of State plans permit retention of annuity and return to State employment with full pay for limited periods.

The committee recognizes the paradox which would result if retirees should be permitted indefinitely to draw full salary plus full annuity under the same staff retirement system. However, some liberalization in this area appears to be warranted, not only as a measure of equity to civil service retirees, but also to give the Government more ready access to needed and proven skills. A 90-day period of combined annuity plus salary, in any 12-month period, appears to be a reasonable limit. Because much of the reemployment would be on an intermittent or part-time basis, it has been considered preferable to express the limit in terms of equivalent hours (90 days times 8 hours per day equals 720 hours). Service in excess of 720 hours in a 12-month period would be at reduced salary as at present; that is, salary would be reduced by the amount of annuity applicable to such period of employment. As a safeguard against excessive earnings, there should be a further condition: that the combined annuity and salary of any employee during a 12-month period may not exceed the current per annum pay of the highest paid position held by the employee during that year. Thus, the maximum employment at full salary plus annuity would be less than 720 hours in a 12-month period if the pay ceiling would otherwise be exceeded.

C. 1. PARTICIPATION IN THE FOREIGN SERVICE RETIREMENT AND DISABILITY SYSTEM

Recommendation

Foreign Service staff personnel and personnel who convert to the proposed new category of foreign affairs officer in State, the Agency for International Development, and the U.S. Information Agency should be brought under the Foreign Service retirement system as proposed in H.R. 6277, as passed by the House on September 9, 1965.

Cost estimate

Fifteen million dollars annually to the FSR fund with a substantial offsetting saving to the CRS fund.

Discussion

Provisions of FSR are similar to provisions of CSR. However, the former provides special benefits for those selected out and it permits retirement at an earlier age than is provided for civil service personnel. The Department of State reports that its best officers, because of their capabilities, are given the most challenging assignments and generally choose to remain until they reach mandatory retirement age. It is the officers whose careers have leveled out and who are rated in the lower portions of their classes who request retirement before age 60. Thus, the early retirement provisions of FSR complement and reduce pressure on its selection-out system and in addition recognize the needs of a career service established to man posts throughout the world, many in hardship areas.

Present participants in FSR include all Foreign Service officers, noncareer officers who serve as chiefs of mission (ambassadors and ministers) for at least 20 years, and Foreign Service Staff personnel who complete 10 years in the Staff Corps under the Department of State. Also, approximately 720 Foreign Service career Reserve officers in USIA have been nominated by the President for appointment as Foreign Service officers. Upon their confirmation by the Senate they will become participants.

The committee believes that participation in FSR should be expanded as necessary to cover all career personnel who are subject to worldwide assignment and to selection out in order that all who serve under the same or similar conditions will be subject to the same restrictions and entitled to the same benefits. This objective would be accomplished by enactment of H.R. 6277, a bill to amend the Foreign Service Act of 1946, as amended, passed by the House on September 9, 1965. The basic objective of this bill is to provide a single personnel system for the three major foreign affairs agencies—State, AID, and USIA. This objective has been strongly endorsed by this administration.

Foreign affairs agencies now operate under two separate personnel systems, FSR and CSR. The question of integrating the personnel systems in these agencies is one that has received considerable attention in the last 20 years. Most major studies of foreign affairs personnel programs during this period have pointed in the same direction—move civil service personnel into the Foreign Service.

H.R. 6277 would accomplish this by adding a new personnel category, foreign affairs officer, to the Foreign Service system. It would authorize the President to provide for the transfer on a voluntary basis of all personnel now in the three agencies into the new foreign affairs officer category or into the existing categories of Foreign Service Staff or Foreign Service Reserve. The bill would also authorize the extension of the selection-out principle to foreign affairs officers and Foreign Service Staff personnel. Present civil service employees who transferred to the Foreign Service, however, would not be required to serve overseas without their written consent.

As an incentive to present employees to transfer to the Foreign Service personnel system with its selection-out feature, the bill would provide, for those who do so, FSR coverage upon their completion of 10 or more years of continuous service in one or more of the three foreign affairs agencies. Future appointees would not be covered under FSR unless they were appointed for worldwide service, in which case qualifying time would also be 10 years. Civil service personnel who chose not to transfer to the Foreign Service would remain under CSR. No new appointments would be made under the civil service personnel system, and eventually all personnel serving in the foreign affairs agencies would be under the Foreign Service personnel system.

Career officers in AID are appointed as Foreign Service Reserve officers and are covered under CSR. H.R. 6277, as passed by the House, would not extend FSR coverage to Reserve officers because, with the exception of AID Reserve officers, most are serving on limited or temporary appointments. However, assuming passage of H.R. 6277, it is contemplated that Reserve officers in AID serving on permanent appointments will be afforded an opportunity to convert to the new foreign affairs officer category and thus to acquire Foreign Service retirement coverage.

C. 2. MAXIMUM ANNUITY

Recommendation

The maximum limitation on a foreign service annuity should be raised from 70 to 80 percent of the high-5 average salary.

Cost estimate

Two hundred thousand annually.

Decision

Traditionally, annuity computation formulas have been designed to limit annuities to some fractional part of employee's average salaries. This is entirely appropriate. However, the committee believes that the maximum limitations should be the same, at least as between CSR and FSR.

Sixty percent of average salary for the 10 years preceding retirement was the maximum established under both systems at their inception. Over the last 40 years, both formulas have been liberalized until today the civil service maximum is 80 percent of high-5 average salary and the Foreign Service maximum is 70 percent of high-5 average salary.

The committee recommends that the Foreign Service maximum be increased to 80 percent of the high-5 average salary so that it equates to the civil service maximum.

The committee considered a proposal to establish a minimum annuity of 50 percent of high-5 average salary for Foreign Service personnel retiring with between 20 and 25 years of service. Justification for the proposal is the substantial risk that careers of Foreign Service personnel will be foreshortened either because of the selection-out program or because of the arduous and unhealthful conditions under which some Foreign Service personnel must serve for substantial periods. The proposal would provide a 25-percent increase in annuities for those retiring with 20 years of service. The committee believes that such a large increase would be both unwarranted and too costly and disapproved the proposal.

C. 3. SURVIVORSHIP PROVISIONS

Recommendations

(a) The formula for reducing annuities of personnel electing survivor annuities for their spouses at the time of retirement under the Foreign Service retirement system should be the same as the formula used under the civil service retirement

system; that is, reduce the annuity by 2½ percent of any amount up to \$3,600 specified as a base for the annuity to a surviving wife or husband plus 10 percent of any amount over \$3,600 so specified.

(b) The percentage of the base annuity to which a surviving widow, eligible widower, or designated beneficiary becomes entitled upon the death of an employee or annuitant under the Foreign Service retirement system should be 55 percent, which is the percentage now authorized under the civil service retirement system.

(c) The provision requiring male participants to provide, at a minimum, a \$2,400 survivor annuity should be repealed. Instead, a provision should be adopted to make survivor annuities automatic unless the retiree elects otherwise.

(d) The provision for a minimum annuity of \$2,400 for the widow of a participant who dies in service should be repealed, provided the social security minimum plan recommended under I.A.4(b) is approved.

(e) Foreign Service officers who retired prior to October 16, 1960, without electing any survivor annuity should have an opportunity now to elect a \$2,400 annuity for a wife to whom they were married at the time of retirement. Those making such an election should have their annuity reduced a total of \$300 a year from the date of the election and, in addition, should be required to refund to the Foreign Service retirement fund the difference between the total amount of annuity payments they received from October 16, 1960, to the date of election and the total amount that they would have received had they elected the \$2,400 survivor annuity on October 16, 1960. The repayment should be made by deducting an additional \$25 a month from the officer's annuity with any amount unpaid at his death forgiven. Paragraph (1) of section 2(a) of Public Law 89-308 should be repealed and any election made thereunder should be considered to have been made under the provisions of this recommendation. A \$2,400 survivor annuity should be granted to the widow of any annuitant who was eligible but who did not elect a survivor annuity hereunder and who dies after February 28, 1966, but before the expiration of 120 days from the date of enactment of this recommendation.

Cost estimate

Seven hundred thousand dollars annually.

Discussion

Recommendations (a) and (b), above, concerning the formula for reducing annuities to provide survivorship benefits for a spouse and the level of the survivorship benefit, will equate Foreign Service and civil service provisions in this area. Identical liberalizations for the civil service were approved in 1962 in Public Law 87-793.

The Committee is also recommending certain other changes in FSR survivor provisions which were made by Public Law 89-308, enacted October 31, 1965. The background of this act, which had been pending for several years, is as follows:

Prior to October 16, 1960, FSR provided that the annuity payable to a surviving widow could not exceed 25 percent of a retired officer's high-5 average. The annuity which he received was reduced by 50 percent of the amount of the annuity which he elected to provide for his widow. As a result of this high cost, many officers were unable to provide a survivor annuity adequate for minimum needs and others felt they could not afford to elect any survivor annuity. Consequently, some widows, particularly those whose husbands retired in the 1930's and 1940's, were left destitute. On the basis of appeals from these widows, the Congress in 1956 authorized the Secretary of State to grant an annuity of up to \$1,200 to those Foreign Service widows he found in actual need and without other means of support.

Living costs continued to climb and in 1960 the Congress found \$1,200 to be too low. It therefore increased certain Foreign Service widows' annuities to \$2,400. It also authorized annuity grants of \$2,400 to Foreign Service widows who were not then entitled either to Federal employees' compensation benefits or to Foreign Service annuities and whose husbands had died before August 29, 1954. At the same time, Congress dropped the needs test as being inconsistent with the annuity principle.

The Congress continued to receive appeals from Foreign Service widows whose husbands died subsequent to August 29, 1954, and who were left without any annuity rights. Therefore, in the Foreign Service Annuity Adjustment Act of 1965, Public Law 89-308, the Congress took the following actions designed to assure that most present and prospective widows will have an annuity of at least \$2,400 a year:

(1) Authorized officers who retired prior to October 16, 1960 (the date the more liberal survivorship provisions became effective for the Foreign Serv-

ice), without electing a survivor annuity of at least \$2,400, to make an election now of a \$2,400 annuity in favor of a wife to whom they were married at the time of retirement. However, those who had not previously elected any survivor annuity and who now make such an election will be required to repay, or their estates will be required to repay, amounts they have received in excess of amounts they would have received had they made the election at the time of their retirement. This will make it inadvisable for some to exercise this option.

(2) Granted a \$2,400 annuity to some 39 widows of Foreign Service officers provided (a) they were married to the officers before the latter retired, and (b) the officers retired prior to October 16, 1960, and died before March 1, 1966, without electing a survivor annuity.

(3) Increased to \$2,400 the annuity of the 16 Foreign Service widows who were receiving less than this amount on the date of enactment of the Foreign Service Annuity Adjustment Act of 1965.

(4) Established a requirement that at a minimum each male participant, married at the time of his retirement, take a reduction of \$300 in his annuity to provide a survivorship annuity for his wife of \$2,400 and also established the complementary provision that the minimum annuity for widows of participants who die in service shall be \$2,400.

The Cabinet Committee believes it is too paternalistic for the Government to require employees to elect survivor annuities. It believes that, with the change in the Foreign Service survivor annuity provision to the more reasonable civil service provision, all who have legitimate requirements for survivor annuities will be able to elect them. The Committee also believes that its recommendation for a social security minimum plan, which will benefit short-service and lower salaried personnel, will make it unnecessary to provide a minimum annuity of \$2,400 for widows of participants who die in service.

The Committee believes the repayment provision in the Foreign Service Annuity Adjustment Act of 1965 affecting retired officers who avail themselves of the opportunity provided therein to elect a \$2,400 survivor annuity to be unfortunate. This provision requires such officers to repay to the FSR fund the difference between the total amount of the annuity they have received and the amount they would have received had they elected a \$2,400 survivor annuity at the time of their retirement. The effect of this provision is to require an officer to repay at the old rate of \$1,200 a year for each year that he retired prior to 1960. Some officers would have to pay back about \$24,000 in order to provide a survivor annuity of \$2,400 and, if they did not live to repay the \$24,000, their estates would be liable for the debt. This will make it inadvisable for most to make such an election.

Such a requirement defeats the purpose of the legislation, which was to provide equity to this group of employees and to their survivors. The justification for making annuity grants to widows and for authorizing still living officers to elect a survivor annuity now was the high cost of electing Foreign Service survivor annuities under the formula in effect prior to October 16, 1960. To require the officer now to pay the same amount for such an annuity as he would have had to pay had the election been made at the time of retirement serves no purpose.

Annuity grants have been made to widows of all officers who retired prior to October 16, 1960, without electing a survivor annuity and who have since died. Widows of officers who retired after October 16, 1960, or who will retire in the future, have had, or will have, the benefit of the more reasonable survivor annuity formula. Also, those who become widows in the future will have the benefit, assuming its adoption, of the social security minimum plan. It seems only fair and equitable to make a similar provision for this relatively small group of wives of Foreign Service officers who retired prior to October 16, 1960. Recommendation (e) above, proposing such action, is similar to provisions contained in H.R. 4170 as passed by the House on August 2, 1965, and which, with certain amendments, became the Foreign Service Annuity Adjustment Act of 1965.

C. 4. FOREIGN SERVICE ANNUITY ADJUSTMENTS

Recommendation

The Foreign Service annuity adjustment formula based on changes in the Consumer Price Index should be made identical to the civil service formula. In addition, current cost-of-living increases should be approved for the Foreign Service comparable to those approved for the civil service under Public Law 89-205, formerly known as the Daniels bill.

Cost estimate

One hundred and thirty-six thousand dollars annually.

Discussion

The Foreign Service Annuity Adjustment Act of 1965, Public Law 89-308, made certain changes with respect to survivor annuities and, in addition, extended to the Foreign Service a cost-of-living annuity adjustment formula. The formula enacted was similar to the formula in the CSR act prior to its amendment by Public Law 89-205. The old formula was enacted because H.R. 4170, which became Public Law 89-308, was drafted long before the Daniels bill was introduced. Because of the legislative logjam that developed in the closing days of the 1st session of the 89th Congress, it would not have been possible to amend H.R. 4170 before adjournment. Rather than delay its passage until the second session, it was passed in its existing form.

This old formula, which delays increases until the cost of living over an entire year has increased by 3 percent over the base period, should be amended to conform to the recently enacted formula for the civil service which provides automatic annuity increases as soon as the cost of living in each of 3 consecutive months increases 3 percent or more over the base period.

Public Law 89-308, applicable to the Foreign Service, will result in an annuity increase effective April 1, 1966, of approximately 4 percent (depending on the average cost-of-living change during 1965) in annuities which commenced prior to January 2, 1965. Public Law 89-205 (formerly known as the Daniels bill) as amended by Public Law 89-314, applicable to the civil service, resulted in a 4.6 percent annuity increase under the revised formula and also provided a supplemental 1.5 percent cost-of-living increase in all annuities which commenced on or before the effective date of the increase. The latter varied from December 1, 1965, to January 1, 1966, depending on the commencing date of the annuity. Public Law 89-205 also authorized an additional 5-percent increase in annuities which commenced prior to October 2, 1956, so that the total increase in such annuities was 11.1 percent. This additional 5-percent increase was granted in recognition of the less favorable formula used to compute CSR annuities prior to October 2, 1956. Since there was no comparable change in the FSR annuity computation formula, this 5-percent increase should not be authorized for Foreign Service annuitants. However, legislation based on the other provisions of Public Law 89-205 should be sought for the Foreign Service in order to provide comparable treatment under CSR and FSR.

We believe that legislation to implement this recommendation should be enacted promptly and that it should not be made a part of an omnibus bill on retirement.

D. 1. FORCE MANAGEMENT AND THE UNIFORMED SERVICES RETIREMENT SYSTEM*Recommendation*

The uniformed services retirement system as now constituted is an effective instrument in maintaining the youth and vitality of the Armed Forces. Any change in the retirement system would have a major effect on military personnel management. Recommendations for fundamental changes should await completion of the comprehensive force management study now being made by the Department of Defense.

Discussion

While MSR, as now constituted, is an effective instrument in maintaining the youth and vitality of the Armed Forces, the rapidly increasing retired rolls and associated increases in expenditures for retired pay have given rise to questions as to whether the system, with its emphasis on retirement of personnel at relatively young ages, is unduly wasteful in terms of trained manpower and retired pay costs. The retirement system as an instrument of personnel management has not been thoroughly reviewed since enactment of the post-World War II changes in the voluntary, mandatory, and disability retirement laws. Marked changes have occurred in the intervening years in the size and composition of the Military Establishment. The size of the active duty forces, present and prospective, is unprecedented in our peacetime history. New concepts, more complex weapons systems, the continuing cold war, and the worldwide deployment of the military forces make it necessary to review MSR to determine if it is supporting the military personnel management function efficiently and economically. The military personnel management system with its many unique problems and features, such as closed procurement and the up-or-out promotion systems, places major reliance on MSR to support this operation. Any change

in the retirement system would have a major effect on military personnel management. The agency most familiar with the problems and complexities of the military personnel management system should conduct the comprehensive study which must necessarily precede any such change. The Department of Defense has undertaken that review.

The Cabinet Committee should not outline or limit the scope of that review, and specific recommendations for any substantive change in the retirement system prior to completion of that review would be premature. However, the Committee's analysis of that system leads to the conclusion that at least the following matters should be considered:

(a) 20-year retirement without regard to age or specialty (1) at the member's option, or (2) involuntarily.

(b) Mandatory retirement at 26, 28, or 30 years of service without regard to age or specialty.

(c) Improved survivorship provisions covering death after retirement. Action on this issue should be preceded by a comprehensive reassessment of provisions and objectives of the retired serviceman's family protection plan in the manner contemplated in recommendation D. 3.

(d) Provision which should be made for persons moving through the military personnel system who are charged in overall compensation considerations with some part of the cost of the retirement system but who never reap any benefit from that system. Questions dealing with the merits of contributory versus noncontributory methods of system financing are closely related to this issue. The Cabinet Committee has concluded that the costs which would be associated with transition of MSR to a contributory basis outweigh the apparent benefits which might be realized (see recommendation D. 2). The Committee recognizes, however, that further consideration of costs as opposed to potential benefits can properly and profitably be undertaken in the course of the Department of Defense review.

The Committee also recognizes a need for evaluation of the existing formula for computing uniformed services retired pay. That formula is distinct from those applied under CSR and FSR, which also differ one from the other in some respects, as do certain of the conditions of eligibility for benefits under each of the several systems. All of these issues lie at the heart of the systems themselves. The Committee believes that, while Federal staff retirement systems should be uniform to the extent achievable, each must be so structured as to help the statutory personnel system in which it operates to maintain a force that is effective for its particular mission. As an element of the retirement system, the retired pay computation formula is closely interwoven with fundamental considerations relating to the problems and complexities of the military personnel management system. Therefore, that formula should properly be evaluated by the Department of Defense in the light of the results of that Department's comprehensive study of MSR.

D. 2. THE NONCONTRIBUTORY RETIREMENT SYSTEM

Recommendation

Since increased costs resulting from transition to a contributory retirement system would significantly outweigh any advantages gained, the noncontributory nature of the uniformed services retirement system should be retained unchanged.

Discussion

MSR has always been on a noncontributory basis. Military pay is in fact depressed by an appropriate amount to account for lack of actual contribution. CSR has been contributory since its inception in 1920, and at least partially funded.

While there are some significant arguments in favor of putting the uniformed services under a contributory system, the arguments against such a move are compelling. This is not a new issue. The Michigan University study commissioned by the Senate Armed Services Committee in September 1960 pointed out that a switch to a contributory plan would be a take-home pay cut and would undoubtedly require a compensating raise in active duty pay scales. It further noted " * * * An almost universal requirement of a contributory pension plan is that a careful account be maintained for each individual employee and that he or his beneficiary be permitted to receive the accumulated value of his contributions, with interest, at the time of his withdrawal or death prior to retirement. In other words, for the employees who do not stay with the system until they eventually reach retirement, a contributory pension plan is simply a forced savings plan. It can easily be seen that if the U.S. Government were forced to increase

military pay scales to take into account a deduction for a contributory retirement plan, the immediate cost probably would be much more than the present cost because a good deal of the additional pay would be going to people who would not remain in service long enough to retire. * * * In addition, there would be large administrative costs resulting from the fact that the Government would in effect be operating a gigantic savings bank for over 2½ million customers with a high "in and out" rate.

The principal advantage to be gained from a contributory system is, in fact, psychological. Unfortunately, there is now wide misunderstanding about the exact nature of military retirement. In many quarters, there is a general failure to recognize that the absence of a contributory system is offset by lower military pay scales which are depressed in an appropriate amount. If the servicemen did make a specifically identified dollar contribution from active duty pay to his retirement system, his subsequent retirement payments might no longer be erroneously viewed as gratuities in these quarters. An additional resulting advantage would be the closer alinement of the military and civilian systems.

However, the accompanying increases in cost previously discussed outweigh resulting benefits, and conformity for conformity's sake is not the goal. Present and prospective costs of the Federal retirement systems are large. The Committee cannot recommend measures calculated to add to these costs unless the resulting benefits clearly justify that course of action. The question of whether there are such potential benefits will be considered further in the course of the force management study which has been undertaken by the Department of Defense (see recommendation D. 1.).

D. 3. SURVIVORSHIP ELECTIONS AND BENEFIT ENTITLEMENTS UNDER THE RETIRED SERVICEMAN'S FAMILY PROTECTION PLAN

Recommendation

Revision of the retired serviceman's family protection plan to provide the right to make survivor elections up to date of retirement is the minimum step needed to overcome nominal member participation. To be effective such action should not increase cost to participants. Amendment of the plan to gain both ends would affect the principle of actuarial soundness. That principle, as well as other basic provisions, requires reassessment. In lieu of immediate action to remedy only the most apparent plan shortcomings, the entire plan should be thoroughly reevaluated in the course of the Department of Defense force management study (see recommendation D. 1.), thus assuring comprehensive measures to best serve the interests of Government and affected individuals.

Discussion

RSFPP permits a serviceman to contribute part of his retired pay toward a survivor annuity. Depending upon the option he elects, the annuity is paid to his widow or eligible children or both when he dies in retirement. Actuarial retired pay reduction factors are applied. Government assumes only the relatively minor cost of administering the plan. Retired pay reductions are substantially larger and annuities significantly smaller than in the case of counterpart plans for Federal civilian employees.

It is clear that RSFPP is not attaining desired objectives owing to minimal participation by eligible members. Less than 15 percent of retirees have elected to participate. A principal cause is the cumbersome and restrictive rule requiring member elections either prior to completing 18 years of service or, failing that, at least 3 years before retirement. That rule has no counterpart under other Federal systems. If eliminated, the increased adverse elections would directly affect the actuarial status of the plan and would make additional financing necessary. The retirement fund accepts this burden under Federal civilian systems. Any increase in existing retired pay reductions under RSFPP to offset these added costs to the system would defeat the fundamental objective of assuring a reasonable level of participation and coverage.

Essentially the same situation pertains in the case of other apparent shortcomings in RSFPP benefit provisions. In view of current CSR and FSR survivor provisions, liberalizations of those systems recommended by the Committee, and recent amendments of other Federal benefit systems such as OASDI, consideration should be given to RSFPP liberalizations in the following areas: benefits for children in school after age 18; benefits for certain remarried widows; and, fundamentally, the necessary "high" cost of RSFPP retired pay reductions since, according to law, the actuarial equivalent method is used.

In this context, the Committee is convinced that revision of RSFPP to provide a right of survivor election up to date of retirement is the minimum step needed. The Committee also believes that many other aspects of the existing plan require reassessment, including those enumerated above. The entire package should be thoroughly reevaluated in lieu of proceeding at this time with only those measures calculated to remedy primary defects. To assure that reevaluation and any resulting system revisions best serve the interests of Government and affected individuals, the required comprehensive review should be accomplished in the course of the force management study which has been undertaken by the Department of Defense (see recommendation D. 1.).

The foregoing does not alter the Committee view that immediate action should be taken to provide tax treatment for uniformed services personnel and their survivors under RSFPP which is equivalent to that afforded to Federal civilian personnel and their survivors covered under CSR and FSR (see recommendation D. 4.).

D. 4. TAX TREATMENT OF RETIREES AND THEIR SURVIVORS UNDER THE RETIRED SERVICEMAN'S FAMILY PROTECTION PLAN

Recommendation

The Federal tax treatment of uniformed services retirees and their survivors under the retired serviceman's family protection plan should be brought in line with the tax treatment accorded retirees and their survivors under the civil service and foreign service retirement systems.

Cost estimate

No significant cost to the Government would result, nor would there be an appreciable revenue effect.

Discussion

Under CSR and FSR, annuity payments to a retired employee which do not represent a return of his own retirement contributions made while on active service are included in his gross income for Federal income tax purposes. However, if the retired employee elects to receive a reduced retirement annuity for the purpose of providing annuity payments after his death to his survivors, he will be required to include only the amount of annuity payments he actually receives during his lifetime, and then only that portion which does not represent a return of his own contributions to a qualified plan made while actively employed. After the employee's death, the annuity payable to his survivors will be included in their gross income for tax purposes when received.

To qualify for the above-outlined tax treatment under existing rules, a survivor annuity plan may not be solely for the employee's beneficiaries. It must be part of the overall retirement system for the benefit of employees, and may be for their beneficiaries as well. Further, the fund into which retirement deductions from salaries and wages are paid should be segregated from other funds of the employer and used only for the payment of benefits under the employee and survivor annuity plan. CSR and FSR have been held to meet these tests, and persons covered thereunder qualify for the favorable tax treatment discussed above. RSFPP has been construed as lacking the characteristics essential to such qualification for participants. A principal reason is that RSFPP benefits are not paid from a segregated trust fund set up by the Government for that purpose. Further, RSFPP technically has been construed as a plan for the benefit of survivors only which was conceived for that purpose and which does not also pay annuities to the retiree himself. These holdings, in turn, are in part responsible for adverse estate tax treatment of RSFPP benefits.

These technical considerations should not operate as a bar to tax treatment for uniformed services retirees and their beneficiaries equivalent to that enjoyed by their counterparts covered by fundamentally similar retirement systems. The imputed contribution to his retirement system from active service pay of the uniformed services member is essentially comparable to the actual contribution withheld from the pay of employees covered by other Federal staff retirement systems. These other employees do not actually receive as active duty pay the contribution they make each pay period to their retirement fund; rather, it is simply involuntarily withheld by the Government, just as the uniformed services member never receives in the form of active duty pay the deferred compensation constituting his imputed contribution toward retirement. Both employee categories accept reduced benefits after retirement; unlike Federal civilian employees, the reductions applied to uniformed services members are computed on an actuarial basis. Finally, RSFPP is, in fact, part of MSR, just as the survivor benefit

provisions applicable to other Federal employees are a part of their respective retirement systems.

Legislative action should be taken to provide for uniformed services members the same tax treatment to which their civilian counterparts are entitled following a similar election to participate in a survivor benefit plan based upon retired pay reduction. H.R. 10625 would have attained that objective, and was introduced in the 1st session of the 89th Congress. The bill had the support of the Departments of Defense and Treasury. It passed the House of Representatives late in the session and was forwarded to the Senate on the day before adjournment, leaving insufficient time for final action by the Upper House.

D. 5. RETIREMENT CREDIT FOR RESERVE SERVICE

Recommendation

For the purpose of computing their retired pay, active duty enlisted members should receive credit for their prior Reserve service on a point-credit basis comparable to the entitlement enjoyed by officers.

Cost estimate

Annually \$1.7 million.

Discussion

In computing his retired pay, an active duty officer may include in his years of creditable service all prior Reserve service performed before June 1, 1958, just as though it were performed on active duty. He may also count all prior Reserve service performed after May 31, 1958, but only to the extent that such service would be creditable in computing the retirement pay of a Reserve officer retiring from nonactive duty Reserve service. Such service is credited on the basis of one point for each day of full-time service or annual training duty; one point for each authorized drill or period of instruction, plus 15 points for each year of membership in a Reserve component, but not more than a combined total of 60 points for these categories in any one year. The sum of the points thus credited is divided by 360.

However, an active duty enlisted member may be retired with pay computed on the basis of his years of active service only. His prior Reserve service, though creditable for basic pay purposes, may not be included in his retired pay years of service multiplier.

Prior Reserve service of active duty enlisted members deserves recognition comparable to that performed by officers. It is equally indispensable to the national defense, though performed in lower grades, different capacities, and at lesser levels of responsibility. Active duty enlisted members should receive credit for such service on a basis reasonably comparable to that enjoyed by active duty officers. They should be granted the point-credit retired pay entitlement for prior Reserve service which is now enjoyed by active duty officers for post-May 31, 1958, Reserve service, and which now also constitutes the basis for retired pay computations of all nonactive duty Reserve officers and enlisted members generally, without regard to whether their service was performed before or after June 1, 1958. Congress has clearly declared its intent to minimize credit for Reserve service performed on or after June 1, 1958. Extension to active duty enlisted members of the point-credit principle implemented at that time would place them in a position comparable to that enjoyed by active duty officers. It would also accord to the prior Reserve service of enlisted members retiring from active duty the same value and dignity now accorded to the Reserve service of the nonactive duty officer and enlisted members of the Reserve components of the Armed Forces.

D. 6. RETIRED PAY ENTITLEMENTS FOR RETIREMENT IN A COMMISSIONED GRADE FROM FULL-TIME ACTIVE DUTY

Recommendation

Nondisability retirement in a commissioned grade from full-time active duty should normally entitle the member to retired pay based on the highest grade in which he served on active duty satisfactorily for not less than 6 months. Existing entitlements to nondisability retirement from active service with retired pay based on a higher grade in which the member may never have served on active duty should be eliminated. Transitional provisions should protect entitlements already earned, but the privilege thus preserved for an active duty Reserve officer based on his higher permanent grade should not survive a subsequent promotion.

Savings estimate

Annually \$1.5 million.

Discussion

Unless entitled to a higher grade under some other provision of law, a member retiring in an officer grade retires in the Regular or Reserve grade held at date of retirement (that is, his permanent grade), with retired pay computed thereon. Statutory authorities for retirement in a higher grade, with retirement pay computed on the basis of that higher grade, include the entitlement to retire in: the highest temporary grade in which the member served on active duty satisfactorily (Army and Air Force require at least 6 months' service); a higher grade for which the member was selected, and to which he would have been promoted had it not been for an intervening physical disability; a higher grade based on service in statutory positions which carried that higher grade entitlement for the incumbent while so serving. In certain other situations in which a member rendered conspicuously distinguished service, the law authorizes retirement in a higher grade in which he may never have served on active duty, but retired pay is computed on the basis of the retired grade to which the member would be entitled in the absence of the higher grade authority.

An Army or Air Force officer on active duty normally receives promotion consideration under a dual system. He is considered for permanent (Regular or Reserve) promotion, at career points prescribed in law, by selection boards constituted for that purpose. He may also be considered for temporary promotion by selection boards appointed by the Secretary. A Regular or Reserve commissioned officer may be promoted to a temporary grade without vacating his permanent Regular or Reserve grade. Under the Army and Air Force promotion systems, individual officers on active duty often concurrently hold different temporary and permanent grades (usually confined to a one-grade difference). Navy and Marine Corps promotion statutes differ in a number of respects and, in combination with related personnel practices, effectively preclude situations which frequently occur in the Army and the Air Force in which an active duty Reserve officer holds a permanent Reserve grade which: is higher than the temporary grade in which he is serving on active duty; is usually higher than any grade in which he ever served on active duty; but nevertheless renders him eligible to retire from active duty with that higher permanent Reserve grade and the correspondingly higher retired pay rate based thereon. This situation would not exist if active duty Reserve officers, like Regular officers, automatically assumed their new grade on active duty when promoted to a higher permanent Reserve grade. A primary reason for not extending this entitlement is that, unlike Regular officers, when reservists compete for permanent Reserve promotions they are competing with all other eligible Reserve officers, including Reserve officers not on active duty, based upon total Reserve commissioned service without regard to amount of such service actually performed on active duty.

The Committee perceives no reasonable basis upon which nondisability retirement from full-time active duty should confer retirement entitlements and emoluments based upon a grade in which the member never served on active duty. Retired pay based on a commissioned grade should normally be authorized upon nondisability retirement from full-time active duty only if an otherwise qualified member has served on active duty satisfactorily in that commissioned grade for a reasonable period of not less than 6 months' duration. Adoption of the 6 months' active-service rule here recommended should not operate to deprive members of entitlements already earned. Therefore, a savings clause should be concurrently enacted preserving the present retired pay entitlement of a Reserve officer selected for or promoted to a higher permanent Reserve grade before the effective date of the recommended change, but the entitlement thus saved should not survive his subsequent promotion.

Application of the 6 months' active-service rule should not affect the more liberal rules applicable to disability retirements, since the latter reasonably and properly take into account the possibility of an intervening physical disability incurred through no fault of the member. Neither should it affect existing rules governing retired grade and pay entitlements under the separate system for reservists retiring from nonactive duty Reserve service.

In reaching these conclusions, the Committee has not attempted to evaluate existing personnel management or promotion procedures in the uniformed services. The Committee recommendation is not directed toward existing procedures governing appointment or promotion of commissioned officers or their individual entitlements to any given rank. Rather, it is directed solely at the issue of nondisability retirement, under the system for members on full-time active duty,

with pay based on a grade in which the member either never served on active duty or in which he served for only a nominal period. It should not otherwise affect uniformed services grade structures or officer rank and promotion systems. The last-mentioned issues and related matters can be more effectively treated in the course of the "Force Management and Retirement Study" which has been undertaken by the Department of Defense.

D. 7. SUPPLEMENTAL GROUP LIFE INSURANCE

Recommendation

A supplemental group life insurance plan scaled to salary should be provided for uniformed services members whose earnings exceed the \$10,000 maximum policy authorized under the existing servicemen's group life insurance system. Salary should be determined using the most stable element of the pay system, by adopting a formula of 18 months times basic pay. Premium costs under the supplemental plan should be borne only by members participating and eligible under the prescribed earnings formula, with the Government assuming costs traceable to the extra hazard of military service. Extension of protection after retirement, other than through conversion, is neither practicable nor desirable due to the nature of the uniformed services retirement system.

Cost estimate

Government share of supplemental plan premiums would approximate \$150,000 annually.

Discussion

Servicemen's group life insurance (SGLI) covers each member of the uniformed services for \$10,000 unless he elects in writing either not to be insured or to be insured in the amount of \$5,000. Private insurance companies are the insurers, but Government effectively assumes the insurance risk associated with extra hazards traceable to military service by paying premium costs associated with those hazards. Cost of insurance to the member is \$2 a month for a \$10,000 policy, or \$1 a month for a \$5,000 policy.

Uniformed services members in lower pay categories now enjoy group coverage on active service at least comparable to their average civilian counterpart in age and pay. Conversely, members in higher pay categories are prevented by the \$10,000 SGLI maximum from acquiring group coverage in amounts comparable to their civilian counterparts. This disadvantage is compounded by growing difficulties encountered in obtaining private insurance without war clause restrictions. SGLI policies are convertible without medical examination at the option of the member at any time before expiration of the 120-day period following release from active duty (including retirement). The converted policy may not be less than the face value of the original and may not require an additional amount as premiums if the insured engages in the military service of the United States. Most retiring Federal civilian employees can retain their group insurance after retirement without further cost to themselves or Government and without change in amount until age 65, with decrease thereafter at 2 percent a month to a floor of 25 percent of original face value.

These SGLI deficiencies should be remedied to the extent possible considering the group characteristics of the uniformed services. A supplemental plan should be provided, related directly to pay, and available only to the extent that individual pay exceeds \$10,000. No portion of premium costs for supplemental plan coverage should be borne by members not covered by the plan. This will avoid providing an immediate additional benefit for a relatively small number of senior members largely at the expense of junior members who would receive no comparable benefit. Cost of the supplemental plan traceable to the extra hazard of performance of active duty should be borne by Government. Earnings requirement for eligible members should be computed using 18 months of basic pay rounded off in the case of odd dollar amounts to the next higher multiple of \$1,000. Annual gross pay should not be used as the measure, since it varies widely with each pay grade based on individual job, place of duty, etc. Basic pay is stable, and on average approximates two-thirds of gross pay. Maximum group coverage should be limited to the equivalent of 18 months of the highest basic pay rate for the senior permanent commissioned grade of major general/rear admiral of the upper half, thus producing a ceiling of \$28,000 under existing pay rates (a ceiling based on level II of the Federal executive salary schedule, now \$30,000, has also been recommended by the Committee for Federal Civilian Employees under FEGLIA). Younger age of uniformed services members at retirement militates against extension of the Federal civilian plan's provision giving free insurance pro-

tection subsequent to retirement. When their active service terminates. The group insurance entitlements of uniformed services members (basic SGLI plus supplemental plan) should be reviewed as a package. A member released with immediate entitlement to retired pay should be treated differently than is now the case under the existing SGLI plan. He should be able to elect at time of conversion any amount of coverage equal to or less than the original face value of his package, and the insurer should not be required to provide special war risk treatment covering the possibility of subsequent active military service. To do otherwise would result in an unnecessary increase in premium rates.

The supplemental plan should not affect basic SGLI premium rates. It should have no significant effect upon Government costs for that basic SGLI plan. Conservative estimates indicate individual premiums under the supplemental plan will approximate 30 cents a month for each thousand dollars of coverage. Cost to Government traceable to the extra risk of military service is conservatively estimated at \$150,000 annually, assuming the current environment remains static.





Relating
SOCIAL
SECURITY
PROTECTION
to the
FEDERAL
CIVIL
SERVICE

A Report Requested By
The Committee On Ways And Means
U.S. House Of Representatives
And
The Committee On Finance
U.S. Senate

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

January 1969



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

OFFICE OF THE COMMISSIONER

REFER TO: P:CD
January 17, 1969

Honorable Wilbur D. Mills
Chairman, Committee on
Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

The enclosed report is submitted pursuant to the direction of your Committee in its report on the Social Security Amendments of 1967 (House Report No. 544, 90th Congress) to the Social Security Administration "to make a thorough study of all the various problems which up to now have precluded the coverage of governmental employees under social security," and to submit a "report of the study, including positive recommendations for covering of Government employees on a basis that is fair to both Government employees and all other workers."

Your Committee's request referred specifically to gaps in the cash benefit protection, difficulties arising from the lack of a satisfactory relationship between Medicare and the Federal employees health benefits program, and the situation in which some Government retirees with annuities based on substantial salary also qualify for minimum or close-to-minimum social security benefits that are weighted to produce an advantage intended for low earners.

Possible approaches to dealing with the situations your Committee referred to in its request were analyzed with respect to their effect on the over-all benefit protection of workers who have Federal employment--those who make a career in the Federal civil service and those whose working lifetimes are divided between the Federal civil service and other employment--and with due regard to the equities of the workers who are covered under and contributing to the social security program. Also a primary consideration was the importance of avoiding any changes in the Federal staff-retirement systems that would be inconsistent with their basic purposes or interfere with their continued independence. In weighing these considerations, we were continually mindful of the desirability of avoiding the incurrence of any additional costs that would not be essential to a solution of those matters which clearly were within the scope of the requested study.

We gave first consideration to an approach involving extension of social security coverage to Federal employment, with the Federal staff-retirement provisions modified to take into account that employees would also be covered under social security--the approach commonly used in private industry and in most other areas of employment. This approach would be more likely than others to assure that the combined benefits (and contributions) of people who move between Federal employment and other work would be at a planned and systematic level. We concluded that the negative considerations, including the high costs involved in a workable coordination of the present provisions of the civil service retirement and social security systems, were of sufficient importance as to indicate that an alternative approach would be preferable. It appears to us that a workable coverage-coordination plan would entail additional costs amounting to at least 6 percent of civil service payroll, and perhaps substantially more. Much of the additional costs would be attributable to increases in the retirement benefit amounts of long service Federal employees, while the objective of our study was concerned with ways of assuring a basic level of benefit protection to all workers who have Federal employment.

Some of the organizations of Federal employees have supported proposals to make social security coverage available to civil service employees on an individual voluntary basis and with no reduction of benefits of the civil service retirement system. We concluded that voluntary coverage would not remedy the problems cited in your Committee's request. The increased costs to the Government would go mainly toward substantially increasing the benefits of those employees who are best able to afford the social security contributions and expect that their social security benefits would represent a high return on the contributions. Further, the adverse selection that would occur under individual voluntary coverage would increase the cost of the social security program at the expense of other workers, who are covered under social security on a compulsory basis.

In considering measures which could provide a satisfactory alternative to social security coverage of Federal employment, we reviewed previously advanced proposals intended to remedy the difficulties cited in your Committee's request and we also explored other possibilities. On the basis of our study we recommend a three-fold approach.

Two of these proposed measures would be applicable to the Federal civil service retirement system, the foreign service retirement system, and the Central Intelligence Agency retirement system. For these staff-retirement systems we propose that:

- (1) Where there is no benefit eligibility under the retirement system when a worker dies, becomes disabled, or retires, credits would be transferred from the staff-retirement system to social security; and

- (2) Where there is benefit eligibility under the retirement system, the staff-retirement system benefits (or if social security benefits based on other work are also payable, the staff-retirement system and social security benefits together) would be guaranteed to be at least as high as if employment subject to the staff-retirement system had been covered by social security.

Our third proposal is designed to establish an appropriate relationship between the Federal employees health benefits program and the Medicare program, and thus would affect practically all Federal civilian employees without regard to their retirement-system coverage. Under this proposal, Federal employees, like workers in private industry, would contribute with their employing agency during their working years toward their health insurance protection after age 65. The retired employee would then have Medicare protection after age 65, paying only the relatively small premium for participating in the voluntary supplemental medical insurance part of Medicare. The Government would make available complementary health insurance that would, together with Medicare protection, provide health insurance protection at approximately the level now provided under the Government-wide high-option plans of the Federal employees health benefits program. To make the plan fully and quickly effective, we are proposing that present Federal retirees be deemed insured for Part A of Medicare, with the cost met by the Government, as employer.

While we do not at this time have definitive cost estimates on the additional costs that would result from adoption of the above-described proposals, it is clear that the combined costs would be very substantially below the cost of a workable coverage-coordination plan.

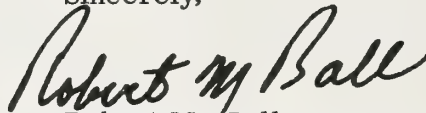
Your Committee's request also referred to situations in which some individuals qualify for Government retirement-system benefits based on substantial salary and also qualify for minimum or near-minimum social security benefits which, though small, provide a relatively high return on social security contributions. In the discussion of such situations in the report, we have indicated possible approaches that could be considered if some action were to be taken. But our special study of this matter showed that the number of such cases is quite small and will decline in the future. We concluded that any legislative change designed to eliminate such cases would give rise to serious inequities, and we recommend against any legislative action to provide for reduction of social security benefits paid to Government employees.

In developing our report, we have consulted with the Civil Service Commission and with the other Federal agencies primarily concerned. We have also carefully considered the testimony of representatives of organizations

of Federal employees on related proposals made in the past, as well as relevant resolutions that have been adopted by Federal employee organizations. We have discussed possible proposals with representatives of the major organizations of Federal employees, and have tried to reflect in the report points brought up in these discussions.

We believe that the measures we are proposing represent a fair and reasonable reconciliation of the divergent views and interests of all who have an important stake in the resolution of the problems cited by your Committee. The proposals appear to be sound and practicable. They would largely solve the major existing problems, at optimum cost, and in a way that seems to us to be fair to employees of the Federal Government and to workers who are covered under social security.

Sincerely,

A handwritten signature in dark ink, reading "Robert M. Ball". The signature is fluid and cursive, with the first name "Robert" and last name "Ball" being the most prominent parts.

Robert M. Ball

Commissioner of Social Security

Enclosure



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SOCIAL SECURITY ADMINISTRATION

BALTIMORE, MARYLAND 21235

OFFICE OF THE COMMISSIONER

REFER TO: P:CD
January 17, 1969

Honorable Russell B. Long
Chairman, Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The enclosed report is submitted pursuant to the direction of your Committee in its report on the Social Security Amendments of 1967 (Senate Report No. 744, 90th Congress) to the Social Security Administration "to make a thorough study of all the various problems which up to now have precluded the coverage of governmental employees under social security," and to submit a "report of the study, including positive recommendations for covering of Government employees on a basis that is fair to both Government employees and all other workers."

Your Committee's request referred specifically to gaps in the cash benefit protection, difficulties arising from the lack of a satisfactory relationship between Medicare and the Federal employees health benefits program, and the situation in which some Government retirees with annuities based on substantial salary also qualify for minimum or close-to-minimum social security benefits that are weighted to produce an advantage intended for low earners.

Possible approaches to dealing with the situations your Committee referred to in its request were analyzed with respect to their effect on the over-all benefit protection of workers who have Federal employment--those who make a career in the Federal civil service and those whose working lifetimes are divided between the Federal civil service and other employment--and with due regard to the equities of the workers who are covered under and contributing to the social security program. Also a primary consideration was the importance of avoiding any changes in the Federal staff-retirement systems that would be inconsistent with their basic purposes or interfere with their continued independence. In weighing these considerations, we were continually mindful of the desirability of avoiding the incurrence of any additional costs that would not be essential to a solution of those matters which clearly were within the scope of the requested study.

We gave first consideration to an approach involving extension of social security coverage to Federal employment, with the Federal staff-retirement provisions modified to take into account that employees would also be covered under social security--the approach commonly used in private industry and in most other areas of employment. This approach would be more likely than others to assure that the combined benefits (and contributions) of people who move between Federal employment and other work would be at a planned and systematic level. We concluded that the negative considerations, including the high costs involved in a workable coordination of the present provisions of the civil service retirement and social security systems, were of sufficient importance as to indicate that an alternative approach would be preferable. It appears to us that a workable coverage-coordination plan would entail additional costs amounting to at least 6 percent of civil service payroll, and perhaps substantially more. Much of the additional costs would be attributable to increases in the retirement benefit amounts of long service Federal employees, while the objective of our study was concerned with ways of assuring a basic level of benefit protection to all workers who have Federal employment.

Some of the organizations of Federal employees have supported proposals to make social security coverage available to civil service employees on an individual voluntary basis and with no reduction of benefits of the civil service retirement system. We concluded that voluntary coverage would not remedy the problems cited in your Committee's request. The increased costs to the Government would go mainly toward substantially increasing the benefits of those employees who are best able to afford the social security contributions and expect that their social security benefits would represent a high return on the contributions. Further, the adverse selection that would occur under individual voluntary coverage would increase the cost of the social security program at the expense of other workers, who are covered under social security on a compulsory basis.

In considering measures which could provide a satisfactory alternative to social security coverage of Federal employment, we reviewed previously advanced proposals intended to remedy the difficulties cited in your Committee's request and we also explored other possibilities. On the basis of our study we recommend a three-fold approach.

Two of these proposed measures would be applicable to the Federal civil service retirement system, the foreign service retirement system, and the Central Intelligence Agency retirement system. For these staff-retirement systems we propose that:

- (1) Where there is no benefit eligibility under the retirement system when a worker dies, becomes disabled, or retires, credits would be transferred from the staff-retirement system to social security; and

- (2) Where there is benefit eligibility under the retirement system, the staff-retirement system benefits (or if social security benefits based on other work are also payable, the staff-retirement system and social security benefits together) would be guaranteed to be at least as high as if employment subject to the staff-retirement system had been covered by social security.

Our third proposal is designed to establish an appropriate relationship between the Federal employees health benefits program and the Medicare program, and thus would affect practically all Federal civilian employees without regard to their retirement-system coverage. Under this proposal, Federal employees, like workers in private industry, would contribute with their employing agency during their working years toward their health insurance protection after age 65. The retired employee would then have Medicare protection after age 65, paying only the relatively small premium for participating in the voluntary supplemental medical insurance part of Medicare. The Government would make available complementary health insurance that would, together with Medicare protection, provide health insurance protection at approximately the level now provided under the Government-wide high-option plans of the Federal employees health benefits program. To make the plan fully and quickly effective, we are proposing that present Federal retirees be deemed insured for Part A of Medicare, with the cost met by the Government, as employer.

While we do not at this time have definitive cost estimates on the additional costs that would result from adoption of the above-described proposals, it is clear that the combined costs would be very substantially below the cost of a workable coverage-coordination plan.

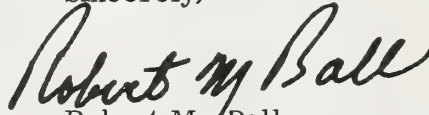
Your Committee's request also referred to situations in which some individuals qualify for Government retirement-system benefits based on substantial salary and also qualify for minimum or near-minimum social security benefits which, though small, provide a relatively high return on social security contributions. In the discussion of such situations in the report, we have indicated possible approaches that could be considered if some action were to be taken. But our special study of this matter showed that the number of such cases is quite small and will decline in the future. We concluded that any legislative change designed to eliminate such cases would give rise to serious inequities, and we recommend against any legislative action to provide for reduction of social security benefits paid to Government employees.

In developing our report, we have consulted with the Civil Service Commission and with the other Federal agencies primarily concerned. We have also carefully considered the testimony of representatives of organizations

of Federal employees on related proposals made in the past, as well as relevant resolutions that have been adopted by Federal employee organizations. We have discussed possible proposals with representatives of the major organizations of Federal employees, and have tried to reflect in the report points brought up in these discussions.

We believe that the measures we are proposing represent a fair and reasonable reconciliation of the divergent views and interests of all who have an important stake in the resolution of the problems cited by your Committee. The proposals appear to be sound and practicable. They would largely solve the major existing problems, at optimum cost, and in a way that seems to us to be fair to employees of the Federal Government and to workers who are covered under social security.

Sincerely,

A handwritten signature in dark ink, reading "Robert M. Ball". The signature is written in a cursive, flowing style with a large initial "R".

Robert M. Ball

Commissioner of Social Security

Enclosure

Relating
SOCIAL
SECURITY
PROTECTION
to the
FEDERAL
CIVIL
SERVICE

A Report Requested By
The Committee On Ways And Means
U.S. House Of Representatives
And
The Committee On Finance
U.S. Senate

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
January 1969

RELATING SOCIAL SECURITY PROTECTION TO THE FEDERAL CIVIL SERVICE

Table of Contents

	Page
REQUEST FOR REPORT.	1
PROBLEM AREAS	3
1. Gaps and deficiencies in the annuity protection of workers who have Federal employment	5
2. Relationship of the Federal employees health benefits program to the Medicare program	8
The Federal employees health benefits program	8
Medicare	9
Difficulties arising from employee mobility	10
3. Annuitants receiving substantial civil service retirement benefits who also qualify for heavily-weighted social security benefits	12
Federal annuitants who receive minimum or near-minimum social security benefits	13
Non-Federal annuitants who receive minimum or near-minimum social security benefits	15
POSSIBLE SOLUTIONS	17
1. Extension of social security coverage to Federal employment subject to the civil service retirement system.	17
Advantages	17
Proposals made in the past	18
Present problems in developing an acceptable coverage plan	19
2. Possible measures which could provide an alternative to coverage	23
a. Transfer of credits to social security.	23
Application of the plan	24
Financing transfer of credits	25
Reverse transfer of credits not feasible	26
Providing new benefits under the civil service retirement system to fill present gaps in protection	27
b. Guaranteed minimum civil service benefits related to social security benefit levels	28
Effect of guarantee on protection	28
Cost of providing the guarantee	30

Table of Contents (continued)

	Page
c. Medicare for Federal employees	30
A plan for relating the FEHB program to Medicare	30
Advantages of the proposed plan	32
Cost implications	32
3. The question of special limitations on social security benefits payable to persons also receiving substantial civil service retirement benefits	33
CONCLUSIONS AND RECOMMENDATIONS	37
APPENDIXES	41

RELATING SOCIAL SECURITY PROTECTION TO THE FEDERAL CIVIL SERVICE

REQUEST FOR REPORT

The Committee on Ways and Means, in its report (House Report No. 544, 90th Congress) on the Social Security Amendments of 1967, directed the Social Security Administration, in consultation with appropriate Federal agencies and employee groups, to study the problems which have precluded the coverage of most Federal Government employees under social security, and to submit recommendations to the Congress. The Senate Committee on Finance concurred in this request in its report (Senate Report No. 744) on the 1967 amendments.

Following is the relevant part of the report of the Committee on Ways and Means:

"Your committee is aware of the gaps which exist in the protection of the Federal workers who do not have survivorship, disability, or retirement protection based on that employment.

"A particular hardship exists in many instances when an individual dies during his first 5 years of Government service, when he is not yet entitled to survivorship protection under his Federal staff retirement system but he has lost his coverage under OASDI. A similar situation occurs when an individual dies shortly after leaving Federal service and before he has worked under OASDI long enough to be covered for survivorship benefits.

"Additionally, an inequity may possibly exist in the relationship of the Medicare program to Federal employees. Approximately 50 percent of our retired Federal employees are entitled to hospital insurance benefits under Medicare on the basis of coverage acquired while serving in the armed services or working in private employment. If the retiree elects to pay the premium for coverage under the voluntary supplementary medical plan open to all of our citizens, he will enjoy health insurance protection approaching that afforded by the high option plans offered by the Federal Employees Health Benefit Act. In that case, the Federal Government is relieved of any obligation to contribute to his health care as an employee distinct from a member of the general public.

"Those Federal retirees not entitled to hospital insurance protection under Medicare cannot benefit from the voluntary supplemental plan toward which the Government currently contributes \$3 per month on behalf of each participant. Since the retiree must retain the health insurance plan he selected as an employee in order to have hospital insurance protection, the voluntary supplemental plan will duplicate coverage he already has. As he is not permitted to collect duplicate benefits, the voluntary supplemental plan is not worth the \$3 per month the individual would be required to pay.

"The Administration's bill, H.R. 5710, contained a proposal under which credits for work subject to a Federal staff-retirement system would be transferred to social security in all cases where the worker or his survivors do not become eligible for staff-system benefits based on that work. Your committee also considered the possibility of extending social security hospital insurance coverage to Federal civilian employment, on the contributory basis that is applicable to such coverage of almost all other kinds of work. Although each of these ideas has some merit, your committee believes there should be further and more comprehensive study of the possible ways of including Federal employees in the program before any recommendation for change is made.

"Of concern to your committee is a situation that can occur when Government employees, either active or retired, work in employment covered under the social security program and qualify for the minimum or low benefits. This situation occurs when the Government worker with a substantial Government salary works part-time under social security or enters covered employment after retirement; in such cases he can become entitled to social security benefits (perhaps the minimum benefit) which will be heavily weighted in his favor, receiving a higher percentage of wage replacement on his social security earnings. The social security weighted benefit formula is designed for the worker who has low earnings from all sources all his working life.

"The committee has directed the Social Security Administration to make a thorough study of all of the various problems which up to now have precluded the coverage of governmental employees under social security. The committee directs the Social Security Administration to conduct this study in close and constant cooperation with employee groups and with appropriate Federal agencies with a view to resolving the problems in a manner that is fair to both the governmental employees and the other members of the labor force that support the OASDI system. The report of the study, including positive recommendations for covering of Government employees on a basis that is fair to both Government employees and all other workers, is to be submitted to the Congress prior to January 1, 1969."

In the following report of the results of our study, we have generally made reference to the Federal civil service retirement system for purposes of describing present problems and possible solutions. That system covers about 99 percent of those Federal jobs that are not covered by social security. Whatever approach might be used to fill gaps in the protection of workers employed under the civil service retirement system could be adapted to some of the much-smaller Federal staff-retirement systems such as the foreign service and Central Intelligence Agency retirement systems. 1/

1/ The principal benefit provisions of the civil service, foreign service, and Central Intelligence Agency retirement systems, and of social security, are summarized in Appendix A.

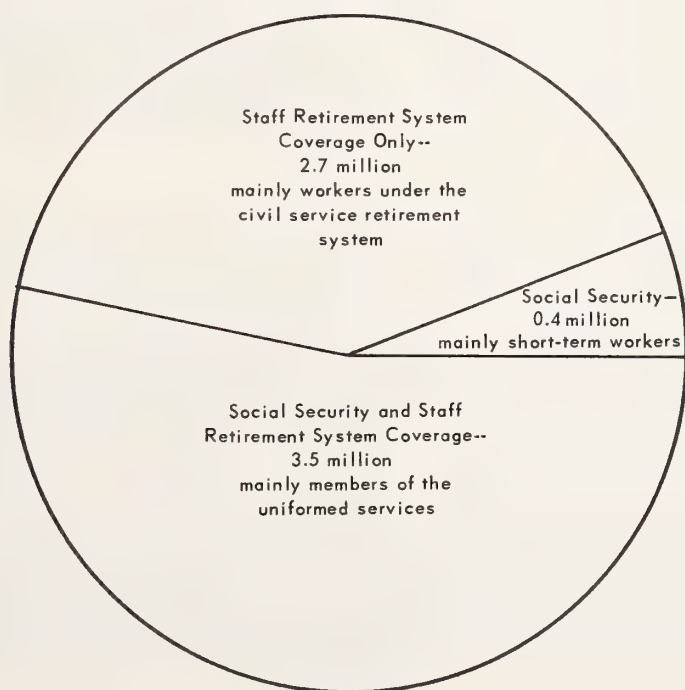
PROBLEM AREAS

There is general agreement that the Federal civil service retirement system is an excellent staff-retirement system, appropriately designed to further the effective administration of the Government. However, the present study, by its nature, is concerned with certain deficiencies in the protection afforded many of the workers who have employment subject to that system, in comparison with the basic family protection afforded workers generally under social security.

The principle that the workers of the Nation should, to the extent possible, be assured that a basic level of family income will continue when the worker's earnings are cut off by retirement, severe disablement, or death is today deeply imbedded in public policy. Almost all workers other than those under the Federal civil service retirement system or under some of the systems for State and local government employees, are in jobs covered by social security, which provides this basic protection. Generally this protection continues without interruption if the worker goes into different employment. Many workers covered under social security have supplementary protection through employer or collective bargaining arrangements, such as private pension, staff-retirement or profit sharing plans.

As shown in the following chart, about 9 out of 10 Federal civilian jobs--representing 40 percent of all Federal personnel--are in employment subject to a Federal staff-retirement system and excluded from social security. Members of the Federal uniformed services and most employees of the Tennessee Valley Authority are covered by both social security and a staff-retirement system.

Chart 1. Retirement system coverage of Federal personnel



The Federal civil service retirement system has developed independently of the social security system and its development has of course been strongly influenced by objectives common to staff-retirement systems--including the objective of encouraging competent workers to make a career in employment subject to the staff-retirement system. The civil service retirement system therefore places main emphasis on adequacy of retirement benefits for long-service employees. Once an employee has completed long service he generally has good disability and survivorship protection as well. 2/

Table 1. CSR retirement benefits for long-service employees, as a percentage of pay.

Years of Service	Retirement Benefits as Percentage of Pay <u>1/</u>
30 years	56 1/4%
35 years	66 1/4%
40 years	76 1/4%
42 years or more	80 %

1/ CSR retirement benefits are computed as a percentage of average pay over the 5-year period of highest pay (generally the last 5 years). Cost-of-living increases, related to increases in the Consumer Price Index, are provided after entitlement.

Conversely, because of the staff-retirement system emphasis on length of service, there are serious gaps in protection, or deficiencies in benefit levels, for large numbers of Federal workers, including career employees who do not yet have long Federal service. These gaps and deficiencies--mainly in family survivorship and disability protection--have been largely eliminated in most other areas of employment subject to staff-retirement systems because the workers also have social security coverage. Under social security, in accord with social insurance principles, full-scale family survivorship protection and family disability protection for young workers arise after 6 calendar quarters of covered work. 3/

2/ Examples of monthly benefits under the civil service retirement system are shown in Appendix B.

3/ Examples of monthly benefit payments under social security are shown in Appendix C. The term "family" is here used to mean a unit that includes at least one dependent child. In survivorship cases involving a widow, but no dependent child, the benefits are in many cases better under CSR than under social security, as CSR pays an immediate annuity if an employee dies after 5 or more years of service, while social security widow's benefits are not payable until age 60, or until age 50 if the widow is totally disabled. However, in cases where the worker had only 5 years of Federal service, the widow's annuity would be 4 1/8 percent of the worker's high-5 average salary. This annuity amount would increase by about one percent of salary for each year of Federal service performed by the worker in excess of 5 years.

1. Gaps and deficiencies in the annuity protection of workers who have Federal employment

The shortcomings in protection of Federal employees and their families affect, at one time or another during their working lifetimes, almost all workers who have employment subject to the civil service retirement system. During their first 5 years of Federal employment, Federal employees, including those who intend to make a career in Federal service, do not have survivorship or disability protection under the civil service retirement system. 4/

About 20 percent of the employees subject to the Federal civil service retirement system, as of any one date, have less than the 5 years of service needed for such protection. While the incidence of death and disability is low among these younger workers, the economic effects on a young family are disastrous when death or total disability does cut off the family income.

Even after an employee has completed 5 years of service and becomes eligible for protection under the civil service retirement system, it generally requires many more years of Federal service before his family survivorship protection under the system reaches the level that would have been afforded by social security if his Federal service had been covered under social security. In some situations family survivorship protection under the civil service retirement system never reaches the social security level regardless of the length of Federal service. In disability cases, the civil service retirement system guarantees certain minimum benefit levels after 5 years of service (generally 40% of high-5-year average pay) which are generally higher than social security provides for a disabled worker who has no dependent family. But family disability protection is in many cases less than under social security because social security provides benefits to family dependents of a disabled worker while the civil service retirement system pays benefits to only the disabled worker himself. 5/ In other situations, the civil service benefits are higher than social security benefits, though exceptions are not uncommon in individual cases.

4/ When a Federal employee with less than 5 years of service dies, becomes disabled, or leaves Federal service, he (or his survivors) receives a refund of his contributions to the civil service retirement system (plus interest if he had at least one year of service). Many employees also carry life insurance under the Federal employees group life insurance program. The Federal employees compensation program provides benefits in the event of work-connected disability or death.

5/ In general, to be eligible for disability benefits under social security a worker must be unable to engage in any substantial gainful activity; under the more liberal definition of disability of the civil service retirement system, an employee is eligible for disability benefits if he becomes unable to perform the duties of his job or a similar job.

The following table indicates the types of situations where benefits payable under the civil service retirement system are generally lower than the benefits that would have been payable if the worker had a similar earnings record in work covered under social security. The table roughly indicates the differences between the amounts of the two benefits for workers with annual pay of \$6,000, \$7,800, and \$10,200, and the number of years of Federal service it would take to yield civil service benefit amounts equal to the social security monthly benefit shown.

Table 2. Illustrative cases in which CSR benefits are less than social security benefits

Beneficiaries	Average Monthly Salary	Monthly Benefits <u>1/</u>		Years of Service At Which CSR Equals SS
		CSR 5 yrs' Service <u>2/</u>	Social Security <u>3/</u>	
Widow and one child	\$500	\$ 78	\$266	40
	650	84	327	40
	850	92	327	31
Widow and two children	500	135	375	\$334 max at 42 years
	650	141	434	\$400 max at 42 years
	850	149	434	36
Surviving child alone	500	69	133	CSR pays flat amount which never reaches SS level
	650	69	164	
	850	69	164	
Totally disabled worker with wife, one child <u>4/</u>	500	200	355	37
	650	260	432	35
	850	340	432	27

- 1/ It is assumed that the worker is employed from age 22 (in 1968) until death or disability.
- 2/ The CSR annuities are those that would be payable at earliest eligibility (i.e., after 5 years of Federal service).
- 3/ Social security benefit amounts, assuming level salary, would be the same if death or disability occurred after 5 years or after a longer period of employment. The maximum annual earnings that can be counted in determining a worker's lifetime average earnings under social security is \$7,800 for 1968 and thereafter.
- 4/ Minimum CSR disability benefit amounts are ordinarily computed at 40% of high-5-year average salary. CSR does not pay benefits to families of disabled employees.

Other inadequacies in protection are associated with the considerable employee mobility between Federal and private employment. In the 5 years from 1963 to 1967, an average of about 400,000 employees a year either entered or left Federal employment covered by the civil service retirement system. Workers who leave Federal employment, whether or not they have 5 or more years of service, immediately lose all survivorship and disability protection under the

civil service retirement system, and a large proportion do not have social security survivorship protection until they have worked at least a year and a half--or social security disability protection until they have worked from a year and a half to 5 years (depending on their age)--after leaving Federal employment. Some of them have never worked under social security. Others have lost social security protection they had once acquired through previous work. A few are still insured for social security survivorship or disability benefits when they leave Federal employment but their protection is generally impaired because social security benefit amounts will not reflect their recent earnings and may be quite low because of the length of time spent in non-covered work.

Many of the workers who shift between Federal and private employment become eligible under only one system--either social security or civil service retirement--for benefit amounts which are low in comparison to total earnings because they lose credit for the years of service they had under the other system. Some workers may end up without eligibility for benefits under either system.

Of the many thousands of workers who each year leave Federal employment in which they are covered by the civil service retirement system, only a small proportion eventually receive a retirement benefit based on their service. Studies of people who left work in which they were covered by the civil service retirement system show that less than 1 in 12 gained and kept any protection under that system as a result of the Federal service. The number of deferred annuities awarded in recent years has averaged less than 4,000 a year. About one-third of those who left did so after they had met the eligibility requirement of a minimum of 5 years of service. Employees who leave after 5 years of Federal service may either take a refund of their civil service contributions (generally without interest) or forego refund and obtain a deferred annuity beginning at age 62. 6/ Of those who separated after 5 or more years of coverage under the civil service retirement system, but before retirement, more than three-fourths voluntarily withdrew their contributions soon after separation and thereby lost all rights to benefits under the system. These rights may be regained only if a worker re-enters Federal employment and is again covered by the system. The following table shows the number of Federal employees who claimed refunds of their civil service contributions in recent years.

Table 3. Refund claims received by the U.S. Civil Service Commission

Fiscal Year	Refund Claims
1963	135,761
1964	127,863
1965	119,376
1966	129,170
1967	164,851

6/ As noted earlier, employees who leave with less than 5 years of service receive a refund, with no option as to a deferred annuity.

2. Relationship of the Federal employees health benefits program to the Medicare program

Enactment of Medicare in 1965 initiated a national policy of providing health insurance under the social security program for persons age 65 and older. A health insurance program for Federal employees and retirees became operative in 1960. Considering that over the years millions of workers will have their working lifetimes divided between Federal employment and work covered by social security, there is a clear need to develop an appropriate relationship between the two programs.

The Federal employees health benefits program

The Federal Employees Health Benefits Act of 1959 makes available to Federal civilian employees and their dependents health insurance protection under a participating private plan of their choice. About 9 out of 10 employees have elected to be covered. The great majority of Federal civilian annuitants who have retired since June 1960 ^{7/} and their survivors have elected to continue their coverage under the FEHB program after retirement. The program is financed on a current basis by premiums paid in part by employees and annuitants and in part by the Government. Employees and annuitants have a choice between high and low option coverage, and a choice among a number of plans. Most of the employees are enrolled in either of two Government-wide plans.

In general, the Government contributes 50% of the cost of low-option coverage and employees and annuitants bear almost all of the extra cost of the additional protection under the high-option plans. About 86% of employees and annuitants select high-option coverage despite its higher cost to them, with the result that, overall, the Government is currently paying about one-third of the cost of the program. Because of the limits set by present law on the amount of Government contributions, an increase in premium rates beginning January 1, 1969, is almost entirely added to the premiums paid by employees and annuitants, and as a result the Government contribution is now about 28 percent of the cost of the program. ^{8/}

Federal employees retiring after June 1960 (and their survivors) pay the same premium rates as active employees, though health care costs for retirees and their dependents are about 2 1/2 times as high as those of active employees and their dependents. The older group makes greater use of the more costly services, particularly hospitalization. The proportion of elderly people in the entire group is certain to increase for some time to come; at present the size of the older segment is considerably reduced by the limitation that only

^{7/} There are special provisions for those retired before July 1960 and their survivors. The great majority have the hospital insurance part of Medicare, many having been covered by a special transitional provision, applicable to people who reached age 65 before 1968, and, like practically all other persons, may at age 65 participate in the supplementary medical insurance part of Medicare.

^{8/} Appendix D shows premium rates of the Government-wide FEHB plans.

those retired since June 1960 are included. With a uniform premium rate for the older and younger members of the group, the young will be paying increasingly higher premiums than what would be required to cover their own health care costs, in order to help finance the higher costs of the older group.

Table 4. Comparison of increases in the cost of hospitalization with increases in the cost of other medical care

	<u>Consumer Price Index</u>					Increase 1960-1967
	1960	1962	1964	1966	1967	
Consumer Price Index	103.1	105.4	108.1	113.1	116.3	+12.8%
Medical care, total	108.1	114.2	119.4	127.7	136.7	+26.5%
Physicians' fees	106.0	111.9	117.3	128.5	137.6	+29.8%
Hospital service (daily service charges)	112.7	129.8	149.9	168.0	200.1	+77.6%

Source: Handbook of Labor Statistics, 1968, Bureau of Labor Statistics

As is true of other health insurance plans, the rising cost of benefit payments under the Federal employee health plans has tended to overtake the income from premiums. The increasing level of benefit payments under the high-option plans resulted in benefit payments exceeding premium income of the plans in 1964, and in benefit costs and other expenses exceeding premium income in 1965. Yearly premium increases for high-option coverage since 1965 and scheduled benefits which are not paid by the FEHB plans to members who are covered by Medicare, have ameliorated the situation. However, the gross benefit cost per capita has continued to rise because of the rising cost and increased utilization of health services, and the increasing proportion of annuitants in the covered group, so that premiums have been further increased beginning with January 1969. 9/

Medicare

Medicare includes two related health insurance programs for persons age 65 and over: "Part A"--a basic plan providing protection against the costs of hospital and related care; and "Part B"--a voluntary supplementary plan covering payments for physicians' services and certain other medical and health services. 10/

9/ Appendix D shows benefit experience by patient category under high-option FEHB plans.

10/ Appendix E summarizes major benefits under Medicare and under the Government-wide service benefits plan (high-option) of the FEHB program.

People covered under Part A are mainly those who have reached age 65 and are entitled to monthly benefits under the social security or railroad retirement programs. Under a special transitional provision, Part A coverage was extended to most other persons who reached age 65 before 1968 and who are not insured under the social security or railroad retirement programs, including some retired Federal employees. However, those Federal employees retiring after June 1960 who are covered or could have become covered under the FEHB program after February 15, 1965, were not brought under Part A by the special transitional provision.

Part A protection (the more costly part of Medicare) is financed on a prepayment basis through a separate earnings tax (at present 0.6% on earnings up to the tax base of \$7,800 a year) paid by employers, employees, and self-employed persons, except that benefits for persons who qualify under the special transitional provision are financed out of Federal general revenues.

Enrollment for Part B protection is open to practically all persons reaching age 65, including Federal employees and annuitants. Part B is financed by a monthly premium (now at a standard rate of \$4.00) paid by the enrollee and a matching amount paid by the Federal Government out of general revenues.

In general, the health insurance protection afforded the aged under Medicare is not far below the level provided under the FEHB low-option Government-wide plans but is substantially below the level provided under the high-option plans. Medicare protection is of course oriented to the aged; it thus does not include the maternity and related benefits provided under the FEHB plans but does include coverage of care in an extended care facility after a hospital stay.

Difficulties arising from employee mobility

The difficulties arising because Federal civil service employment is not covered under Medicare, like some of the difficulties arising in the cash benefits area, are associated with the considerable movement of workers into and out of Federal employment. Inequalities in protection, subsequently discussed, result for many of these workers who, on reaching retirement, will have contributed to both Part A of Medicare and to the FEHB program. The number of workers contributing to both Part A of Medicare and the FEHB program ^{11/} is much larger than the number whose cash benefit protection is affected because of the movement between work covered by the civil service retirement system and work covered by social security. This is so because many of the 300,000 temporary Federal employees (covered under social security and excluded from civil service retirement system coverage) participate in the FEHB program. Data for recent years show that, when movement into or out of temporary Federal jobs is included, about one million employees a year are involved.

^{11/} Active Federal employees as a group contribute toward the protection of retired workers because, while the premium rates of active employees are the same as those of retired workers, their health care costs are much lower than those of retired workers.

On reaching age 65, the many workers who contribute under both programs will be in one of the following categories:

- (a) Eligible for health insurance protection under one of the two programs, with no advantage obtained from contributions that were made to the other program. For example, over the long run, when 10 years of social security coverage will be needed to be insured under Medicare, a worker might contribute under the Medicare program for 8 or 9 years, and then go into Federal employment for the remainder of his working lifetime. On the other hand, a worker might have coverage under the FEHB program for a number of years, during which he contributes toward the protection of older members of the program, and his FEHB protection terminates when he leaves Federal employment. In both cases, the worker has contributed for a time to health benefits for others and not for himself.
- (b) Eligible under both programs, but with considerable duplication of health insurance protection. This group gets somewhat better protection than that afforded under the FEHB plans alone, but not the full value of the protection of both Medicare and FEHB. Under nonduplication clauses in the Federal employee health benefits contracts, the FEHB plans do not pay health care expenses that are payable by Medicare.

Federal employees who qualify for Part A of Medicare on the basis of social security contributions paid during only part of their working years receive the same level of Medicare protection as workers who are regularly in employment covered by social security and who pay social security contributions throughout their work lifetimes. This raises a question of equity from the standpoint of those who are covered under the social security program for all or almost all of their working years and who pay not only toward their own Medicare protection but also bear part of the cost of Medicare protection obtained by workers who are in Federal employment during a substantial part of their working years.

- (c) Not eligible under either program. The public policy implemented by the Medicare program--that workers generally should have health insurance protection after age 65--brings into question the propriety of an arrangement under which some civil service retirees do not have such protection. In most of the instances involving civil service retirees, the lack of protection is attributable to a choice made by the individual. No such choice is available to workers generally, as the public policy objective is not only the protection of individuals but also the protection of society as a whole against the adverse effects of dependency in old age.

3. Annuitants receiving substantial civil service retirement benefits who also qualify for heavily-weighted social security benefits

The social security program, in accordance with social insurance principles, provides heavily-weighted benefits for persons who have had especially low earnings over their whole work lifetimes and whose benefits would be inadequate for minimum sustenance if their average earnings were replaced in the same proportion as provided for higher-paid workers. Such benefits, though low, represent a high return on a worker's social security contributions. The House Committee on Ways and Means and the Senate Committee on Finance expressed concern about situations in which a career Government worker with a substantial salary (which is of course the basis of a substantial retirement annuity in the case of long-term workers) has a relatively short period of social security coverage, credits for which yield a low lifetime average of earnings covered under social security because the divisor for determining this average includes many months of noncovered employment. This results in his receiving the heavily-weighted social security benefits not intended for payment to a beneficiary who actually had substantial earnings while he worked in covered employment.

As the following chart indicates, the weighting in the social security benefit formula is heaviest at the average-earnings levels where the minimum benefit (\$55 a month--\$660 a year--for a retired worker) is payable. Benefits begin to exceed the minimum when average earnings reach \$900 a year. The weighting in the formula is diminished rapidly as the average earnings reach levels in excess of \$1200 a year.

Chart 2. Percentage of covered pay replaced by social security benefits payable to a single retired worker

Average Annual Earnings <u>1/</u>	Percentage of Replacement
\$600	110.0%
900	73.9%
1200	71.5%
2400	50.8%
3600	42.4%
6000	35.5%
7800	33.5%

1/ Lifetime average earnings for social security computation purposes.

Federal annuitants who receive minimum or near-minimum social security benefits

Preliminary data from a current study indicate that a little more than 40 percent of annuitants retired from the Federal service who were included in the study were drawing social security benefits. ^{12/} The distribution of those receiving both benefits is as follows:

Table 5.

Amount of monthly social security benefits (as of February 1968)	Percent of dual beneficiaries
\$55 or less	35.0
\$55.10 - \$84.90	26.0
\$85.00 and over	39.0

The median civil service annuity for those receiving minimum social security benefits (\$55 or less) was about \$190 per month, compared with about \$210 per month for all civil service annuitants. The median civil service pay (high-5-year average) of those receiving minimum social security benefits was about \$4,800 compared with about \$5,000 for all annuitants. The median civil service annuity of annuitants receiving social security benefits represented 26 percent of high-5 average salary. ^{13/} When social security benefits are included, the median wage-replacement ratio rises to 41 percent which is only a little higher than the ratio (37 percent) for annuitants not receiving social security benefits.

Thus it is apparent that while more than 40 percent of the annuitants are drawing social security benefits, many of those receiving both benefits have sufficient periods of social security coverage in work other than Federal employment to get social security benefits that are above the minimum and close-to-minimum amounts. Of those who receive minimum or close-to-minimum social security benefits, many get relatively low civil service annuities, reflecting either low salaries, or short service, or both. As a result, most dual beneficiaries receiving heavily-weighted social security benefits do not get total benefits under the two systems that are excessive in relation to their prior earnings.

Of those retirees whose annuities may be regarded as "substantial" and who also get minimum social security benefits, about 13 percent had 35 or more years of civil service, and another 9 percent had 30-34 years of service; approximately 7 percent had high-5-average civil service pay of \$7,800 or more and another 16 percent had high-5-average pay of \$6,000-\$7,799.

^{12/} The number of civil service retirees (including disability retirees) in the study is 497,609--86 percent of all annuitants.

^{13/} For purposes of this calculation, salaries earned by annuitants in the past when salary levels were relatively low have been adjusted to permit comparison with current annuity amounts which have been increased from time to time to compensate for cost-of-living increases, as well as with social security benefit amounts.

For purposes of determining the size of the group (insofar as Federal employees are involved) with which the Committees are most concerned, we have considered several combinations of criteria. For example, the group could reasonably include Federal civil service annuitants with (a) 35 years or more of public service (the Federal civil service retirement system pays annuities based on 35 years of service that replace 2/3 of the annuitant's high-5-average salary); (b) a high-5 average roughly equal to or more than the average annual pay of Federal employees in the United States--about \$8,100; and (c) a social security benefit under \$85 a month (the most heavily-weighted social security benefit amounts fall below \$85). In the current study persons with 35 years of service, a high-5-average salary which when adjusted to today's wage scales would equal roughly \$8,100, and a social security benefit under \$85 a month, number approximately 6,200 people out of 581,000 retirement annuitants, or about 1.1 percent.

Alternatively, the length-of-service criterion could be set at 25 or 30 years, though over the long run workers with Federal service totaling 25 or 30 years will be more likely than those with 35 or more years of service to have substantial periods of employment covered under social security and thus would be likely to qualify for social security benefits above the minimum and near-minimum levels. The civil service retirement benefits of Federal employees with 25 to 30 years of service would be from 15 to 30 percent below the benefits of workers with 35 years of service and the same high-5-average salary, and their combined social security and civil service benefits would not be likely to be excessive in relation to their lifetime earnings. Even a person with 35 years of Government service who had a high-5 average of \$7,800 (and a salary at the time of retirement probably in excess of \$650 a month), would, if also receiving the social security minimum benefit, have a monthly income from both benefits of \$486--a reduction of over 25 percent from the level of his Federal salary at retirement. If annuitants with from 30 to 34 years of Federal service were also included in the group under consideration, the sum of the civil service and social security retirement benefits of some members of the group would represent a reduction of income in retirement of as much as one-third.

Of all persons in the study who are getting both civil service retirement annuities and heavily-weighted social security retirement benefits, about 1,550 receive combined benefits that replace more than 80 percent of their high-5-year average pay in Federal service. These 1,550 annuitants constitute 0.6 percent of the total number (about 250,000) who receive benefits from both civil service retirement and social security.

The number of cases in which long-term Federal employees receive heavily-weighted benefits under social security as well as substantial civil service retirement benefits will gradually decrease as longer periods of covered work are required to become insured for social security retirement benefits, and as a result of social security coverage having become more universal. A

man reaching age 65 in 1969 will need 18 quarters of covered work to be insured for social security retirement benefits; eventually--by 1991--40 quarters of coverage will be required for insured status.

The social security coverage of a worker who is in covered work for 10 years or more would in most cases reflect full-time employment rather than occasional or part-time work. Social security benefit amounts based on at least 10 years of full-time covered work will almost always be somewhat above the levels where the benefits are heavily-weighted, though over the long run the benefit amount obtained by the 10-year worker will of course be much smaller than that obtained by the worker covered during his entire work lifetime. There will of course always be a few cases in which workers whose primary employment is not under social security will get 40 or more quarters of coverage through secondary employment that is intermittent or part-time.

Non-Federal annuitants who receive minimum or near-minimum social security benefits

The type of situation about which the Committees expressed concern obviously is not limited to Federal civil service retirees. The situation arises in all areas of employment where the worker is covered under a staff retirement system but not under social security. A major area is that segment of employment for State and local governments, which is not covered under social security, involving about 2.4 million public workers, whose public employment is covered by a staff retirement system. Instances of benefit payments made by both social security and those State and local government retirement systems whose members are not covered by social security are comparable to those arising between social security and the Federal civil service retirement system. Such situations also occur with respect to a sizeable number of retired railroad workers who receive retirement benefits under both social security and the railroad retirement system, despite a limited coordination of the two programs. The problem also is present, to a less significant extent, in employment for those few nonprofit organizations which have not chosen to cover their employees under social security.

POSSIBLE SOLUTIONS

1. Extension of social security coverage to Federal employment subject to the civil service retirement system

Social security coverage of Federal employment subject to the civil service retirement system--i.e., coverage on the same mandatory contributory basis that is applicable to virtually all areas of private employment, to temporary Federal employees and to all members of the Federal uniformed services--has long been recognized as having certain advantages over other possible ways of relating the protection provided by the social security and civil service retirement systems.

Advantages

Social security coverage would afford Federal employees the combination of basic protection under social security and supplemental protection under a staff plan that has been afforded many other workers who are covered under staff-retirement, private-pension, or profit-sharing plans. It would fill gaps in survivorship and disability protection of short-service workers since social security survivorship protection, and disability protection for young workers, would arise after as little as 6 quarters of coverage. It would provide carryover survivorship and disability protection for workers who leave Federal employment before retirement since social security credits would continue to be built up during periods of Federal employment. The deficiencies in protection of many of the Federal employees with 5 or more years of Federal service would be overcome because benefit amounts would always be at least at the social security level.

Under present law, some workers who are in Federal employment during the major part of their working lifetime also have some social security credits based on other work, but not enough credits to be insured under social security. Social security coverage of Federal employment would assure that such credits would count toward benefits; the credits would be added to the social security credits based on covered Federal employment and would augment a worker's lifetime social security benefit.

Social security coverage would assure Medicare protection at age 65 for all Federal employees and their spouses. Present overlaps between Medicare and the Federal employees health benefits program could thus be eliminated and the latter program could provide planned supplementation to the Medicare benefits for retired Federal employees.

In all instances in which working lifetimes are divided between work now covered by social security and work subject to the civil service retirement system, the monthly benefit amounts payable would be reasonably related to lifetime earnings and contributions.

Proposals made in the past

When the Social Security Act was passed in 1935, the Federal civil service retirement system was a well-established system, already having been in operation for 15 years. The importance of considerations such as the impact of employee mobility was not immediately recognized. Also, the benefits initially provided under the new social security program were relatively low, and did not include the survivorship, disability, and Medicare benefits that are now an important part of social security protection. All other public employment, as well as large segments of private employment was also excluded from social security coverage initially, and was not included until the coverage of the program was greatly expanded in the 1950's.

It subsequently became increasingly evident that the failure to relate staff-retirement system protection of Federal employees to the social security program has created serious difficulties for many workers who have Federal employment, and for their families. Early efforts and recommendations were largely aimed at extension of social security coverage to Federal employees on the contributory basis applicable to employees in industry, generally with the benefits and contributions to the civil service retirement system reduced to take into account the social security benefits and contributions. The 1948 Advisory Council on Social Security, established by the Senate Committee on Finance, recommended that a plan be developed for covering Federal civilian employees under social security, and that as an immediate temporary measure some of the gaps in protection of Federal employees be filled by transferring credits to social security. In 1953, the Subcommittee on Social Security of the House Committee on Ways and Means (Curtis Subcommittee) recommended that Federal civilian employees be covered by social security, with appropriate adjustments made in the civil service retirement system.

The Committee on Retirement Policy for Federal Personnel (the Kaplan Committee) in 1954 recommended specific plans under which virtually all personnel of the Federal Government would be covered under social security. Under the plan applicable to the civil service retirement system, the civil service benefits and contributions would have been reduced to take into account that social security benefits and contributions would be payable, but the overall protection afforded civil service employees would have been substantially improved. The Eisenhower Administration in 1956 recommended that Congress enact proposed legislation carrying out the Kaplan Committee recommendations. The Congress extended coverage to members of the uniformed services but continued to exclude civilian employees subject to the civil service retirement and other staff retirement systems. Subsequently, other coverage recommendations were made, and bills addressed to the problem were introduced in the Congress, but none was enacted.

Present problems in developing an acceptable coverage plan

In view of the independent development of the civil service retirement and social security systems over a long period of time, and because of the benefit liberalizations in the civil service retirement and social security systems since the mid 1950's, the extension of social security coverage to civil service employment would now entail high costs.

The civil service retirement system is financed by employee contributions, currently 6 1/2 percent of pay, and by a matching contribution from the Government. The normal cost (13.86 percent of payroll) is defined as the percentage of the salaries of new employees that is required to be paid into the civil service retirement and disability fund, from the time they enter service until they leave service, in order to accumulate sufficient amounts to pay their benefits. When the fund was originally established, credit given to employees for their prior service during which "normal costs" had not been paid, created a "deficiency" liability, which has grown through the years for various reasons, such as liberalization of benefits (including benefits based on prior service) and more recently by automatic cost-of-living increases in annuities. The deficiency now amounts to \$53 billion so that 13.86 percent of payroll (normal cost) plus financing of the deficiency is required for level financing of the system.

The social security employee contribution rate for 1969 is 4.8 percent of pay up to \$7,800 with a matching amount paid by the employer. The contribution rate is scheduled to rise to 5.9 percent of pay for 1987 and following years, so that the combined contribution rates for the employee and employer are scheduled to level off at 11.8 percent of pay up to \$7,800 a year.

Accordingly, the extension of social security coverage to Federal employment without making adjustments in the civil service retirement provisions (herein referred to as the fully-additive approach) would cost--based on the systems' cost discussed above--over 25 percent of pay up to \$7,800 and 13.86 percent of pay above \$7,800, apart from the financing of the deficiency liability of the retirement fund.

A fully-additive approach would go beyond filling gaps in the retirement, survivor, and disability protection of those who shift between Federal employment and other work and would provide benefit amounts which for many career employees would be very high when compared with prior earnings levels. Since Federal workers could get full benefits under both the civil service retirement system and the social security system, it would not be rare, under this approach, for Federal workers to retire with benefits that equal or exceed their salaries. For example, an individual who worked in Federal employment from age 22 to 65, with a high-5-average of \$10,000 would receive a basic civil service retirement benefit of \$8,000 a year. Under social security he and his wife, after she reaches 65, would get social security benefits (based on an average of \$7,800 a year for social security purposes) of \$3,876 a year. Their total benefits under civil service and social security would be \$11,876 a year--more than 118 percent of high-5-average salary.

Thus a substantial part of the cost of extending social security coverage to civil service employment would not go toward filling gaps in protection but toward increasing the total retirement benefits (under civil service retirement and social security together) of long-service Federal employees who now, under present law, can get substantial benefits. Employees with 35 or more years of service receive retirement benefits which replace 66 1/4 percent to 80 percent of their high-5-average salaries.

The fully-additive approach has been used to extend social security coverage to some Government employees. ^{14/} Social security coverage has been extended to employees covered under some State and local government retirement systems without adjustments in the provisions of the staff-retirement systems. In most such cases, however, the staff-retirement system benefits payable were low, and when social security benefits were added the resulting total was generally well below the level which would be reached by adding social security benefits to those of the Federal civil service retirement system.

A consideration which would be applicable to any plan involving compulsory social security coverage of Federal employees is that some employees believe they would not receive, because of their personal situation, enough additional financial advantage from the social security coverage of their Federal work to make it personally advantageous to pay social security contributions.

Some Federal employees who intend to remain in Federal employment until they retire but who expect to qualify for social security benefits on the basis of non-Federal work, regard the advantage accruing from additional social security coverage as not worth the additional contributions they would pay. Because social security benefits based on low average earnings are heavily-weighted, the increases in social security benefits from the coverage of Federal work for people who are already insured for social security benefits on the basis of non-Federal work would not be as large relative to the social security contributions they would pay on the basis of their earnings from Federal employment as in the case of the benefits which would be payable without Federal coverage; however, for most such employees the additional social security protection would still represent a good buy.

^{14/} When social security coverage was extended to the Federal uniformed services in 1956, various existing survivor provisions were adjusted to take the social security coverage into account but no reduction was provided in the retirement benefits under the existing staff-retirement systems. One consideration was that the formula for computing the retirement benefits--both the social security benefits and the staff-retirement benefits--of members of the uniformed services is applicable to military base pay and thus does not reflect the value of noncash items which represent a substantial part of the total pay of most servicemen. (Most servicemen do not qualify for staff-retirement benefits. To improve the social security protection resulting from coverage of the military base pay, the Congress provided, beginning with 1968, additional social security wage credits, generally \$100 a month, for active duty service.)

In many cases, women Federal workers expect to qualify for a wife's or widow's social security benefit on their husband's account and believe that it would not be to their advantage to have their Federal work covered under social security and to pay the social security contributions. Finally, some older employees who have had no previous social security coverage may expect that they will not be covered under social security long enough to become insured before they retire.

Some employee organizations have expressed their belief that social security coverage of employment subject to the civil service retirement system should be optional for each employee. Optional social security coverage, however, would not fill the gaps in protection because many of those most needing social security protection would not elect coverage. On the other hand, the coverage would probably be elected by higher-paid employees who could afford to pay the additional contributions, and so the Government's increased cost would largely go toward enhancing the benefits of this group.

Alternatively social security coverage could be extended to Federal employment covered by the civil service retirement system, with some reduction in benefits and contributions under the civil service system to take account of the benefits and contributions of the social security system (herein referred to as a coverage-coordination approach). Any coverage-coordination plan that could be considered realistic would be designed so that the combined protection provided under the civil service retirement system and social security would--for every employee--be at least equal to and usually somewhat superior to that provided under the present civil service retirement system alone.

The coverage-coordination approach more than any other has the potential for assuring that, in the case of people who shift between Federal employment and other work, there is a reasonable relationship between benefit amounts, lifetime contributions, and service. Under this approach, the combined benefits payable under social security and the civil service retirement system (and also the combined contributions) would be at a planned and systematic level, since the civil service retirement system benefit levels would be modified to take into account that social security benefits would also be payable.

However, a coverage-coordination plan would require increases in certain benefits above the increases necessary to fill gaps in protection, particularly retirement benefits for many long-term career employees, which have already been considerably increased in recent years. Such increases would result because of the need to avoid deliberalizing present benefits of some other employees. For example, if an unmarried worker's civil service retirement benefit is reduced under a given formula so that the total of his reduced annuity and his social security benefit is slightly in excess of the civil service retirement annuity provided under present law, the same formula will, in effect, give a married worker with a somewhat similar record of earnings and service a substantial increase because of the social security wife's benefit that will be payable to his spouse.

Thus if civil service retirement benefits, adjusted under a coverage-coordination plan, are set high enough to assure that the sum of the civil service and social

security benefits will be in all instances at least as high as present civil service benefits, large increases, which seem difficult to justify, would result in the combined benefits which would be payable in some cases. Such increases in benefits would increase the cost of the coverage-coordination plan beyond what is necessary merely to fill gaps in existing protection. 15/

Organizations of Federal employees have generally objected to any coverage-coordination proposal because they apparently fear that once social security coverage is provided the role of the civil service retirement system in providing protection for Federal employees would become much less important and that further improvements in their retirement, survivors, and disability protection would tend to be limited to those made in the social security system.

Many present Federal employees with long service apparently believe that a coverage-coordination approach, looked at from a personal point of view, would not increase their overall protection enough to make social security coverage desirable for them. Further, annuitants under the civil service retirement system can earn any amount in non-Federal work without such work affecting their annuities, while social security beneficiaries may have part or all of their benefits withheld under a retirement test which applies to all earnings. 16/ Therefore, long-term career Federal employees who expect to work in non-Federal employment after reaching social security retirement age anticipate that they would lose by getting only the reduced benefit under the civil service retirement system, and no social security benefit, for a period of time after they leave Federal employment.

These existing problems, which up to now have precluded coverage under social security of Federal employment which is covered under the civil service retirement system, have led other groups who have studied the matter in recent years to seek solutions in alternatives to direct coverage. Such alternatives were presented by the President's Cabinet Committee on Federal Staff Retirement Systems, which reported its findings and recommendations in 1966; the United States Civil Service Commission and the Social Security Administration, which jointly reported their findings in 1965; and the Advisory Council on Social Security which also reported in 1965. 17/

15/ While the cost of a coverage-coordination plan would depend on the specific provisions of the plan, it appears that any workable plan would have a "normal" cost of 6 percent of civil service payroll (3 percent each for employer and employee) and might well cost substantially more.

16/ Under the social security retirement test, benefits are paid to people under age 72 only if they are substantially retired from work. Generally speaking, a beneficiary who earns less than \$1,680 in a year receives all his social security benefits; a beneficiary who earns more than \$1,680 in a year has \$1 in benefits withheld for each \$2 in earnings between \$1,680 and \$2,880, and for each \$1 of earnings above \$2,880.

17/ Earlier reports on social security and Federal employment are summarized in Appendix F.

2. Possible measures which could provide an alternative to coverage

We considered a number of measures which might be adopted as an alternative to the extension of social security coverage to civil service employment. Among the possibilities considered were the following, each of which would deal with one major aspect of the existing problems:

- (a) Where there is no benefit eligibility under the civil service retirement system when a worker dies, becomes disabled, or retires, credits could be transferred from the civil service retirement system to social security.
- (b) Where there is benefit eligibility under the civil service retirement system, the civil service benefits (or if social security benefits based on other work are also payable, the civil service and social security benefits together) could be guaranteed to be at least as high as if employment subject to the civil service retirement system had been covered by social security.
- (c) Medicare hospital insurance coverage (Part A) could be extended to all Federal employees; they could then advantageously participate in Part B (voluntary supplementary medical insurance) of Medicare, and complementary health insurance could be made available under the Federal employees health benefits program to provide more comprehensive protection after age 65 than is provided under Medicare.

The above-described measures would be concerned with remedying the principal difficulties that have arisen in the absence of social security coverage of civil service employment. They would not achieve all of the results that would be achieved by extension of coverage. For example, they would not prevent situations in which some long-service Government retirees also qualify for minimum or near-minimum social security benefits, nor would they permit Government retirees to get retirement credit for relatively short periods of social security coverage--insufficient to make them insured under social security. Various possibilities which might achieve these results were also studied.

Following is a more detailed description of possible measures which could, in combination, provide an alternative to extension of social security coverage to civil service employment.

a. Transfer of credits to social security

Credits would be transferred from the civil service retirement system to social security for the Federal service of--

- (1) People who die, become disabled, or separate from work covered under the civil service retirement system after less than 5 years of Federal service. Example: Worker becomes totally disabled or dies after working one year under social security and then 4 years under civil service retirement. Under present law no monthly benefits would be payable under civil service retirement or social security. Under the transfer-of-credit plan, if the worker were disabled he would get

monthly social security benefits of \$218, and if he has a wife and child, the family would get benefits of \$432; if he died his widow and child would get monthly social security benefits of \$327. 18/

- (2) People who separate after 5 or more years of Federal work, obtain refunds of their contributions to the civil service retirement system, and later die, become disabled, or retire. 19/ Example: Worker has 6 years of employment under the civil service retirement system, and separates, taking a refund of civil service retirement contributions. He then works one year under social security, and then dies. Under present law, no monthly benefits would be payable under civil service retirement or social security to his widow and two children. Under the transfer-of-credit plan, monthly social security benefits of \$434 would be payable to the surviving family. 18/
- (3) People who separate after 5 or more years of Federal work, do not take refunds of their contributions to the civil service retirement system, and die or become disabled before age 62. Example: In the case given in the previous example (except that there is no refund) no monthly benefits would be payable under civil service retirement or social security to the worker's widow and two children under present law; under the transfer-of-credit plan, monthly social security benefits of \$434 would be payable to the surviving family. 18/

Application of the plan

The transfer-of-credit plan would be applicable to Federal employment performed on or after a specified future date, such as the first day of the year following the enactment of legislation. For those in Federal employment on the effective date, the plan would also be applicable to employment during the preceding 1 1/2 year period, thus assuring immediate survivor protection for the families of such workers. No credits for Federal service would be transferred to social security until a valid claim is filed on the social security account of a worker who had Federal employment covered under the civil service retirement system, and it has been determined that the worker is not entitled to protection under that system.

18/ Appendix F shows additional illustrative monthly benefits that would be payable under a transfer-of-credit plan. The above benefits are computed on the basis of assumed earnings of \$7,800 a year in civil service retirement or social security work.

19/ As subsequently explained, under the transfer-of-credit plan, there would be withheld from refunds of civil service contributions an amount equal to the social security contributions which the worker would have been required to pay if his Federal employment had been covered under social security.

Financing transfer of credits

The financing provisions of a transfer-of-credit plan should be designed to allocate as fairly as possible between the social security and civil service retirement systems the cost of the social security benefits that would be paid under the plan. This objective could be achieved by providing that the social security trust funds be reimbursed annually, with interest from the date of benefit payment, for the proportionate cost, attributable to transferred credits for Federal service, of social security benefits paid during the year.

For example, if in the case of a deceased employee the total earnings credits for Federal service transferred to social security were \$8,000 and credits previously earned under social security were \$16,000, the transferred civil service credits would be one-third of the combined amount of the social security and civil service retirement credits (one-third of \$24,000). If in this case the surviving family had been paid social security benefits of \$3,000 during the year, the social security trust funds would be reimbursed for \$1,000 of the cost of the benefits paid--the proportionate cost attributed to the transferred credits.

A substantial part of the cost of the benefits--the only part of the cost borne by employees--would be met by those employees who would have credit for their Federal work transferred to social security; the civil service retirement system would withhold from all refunds of contributions to employees who separate (or to their survivors) an amount equal to the social security contributions that the worker would have been required to pay if his Federal employment had been covered under social security. The amounts so withheld (and the interest earned on them) would be available in the civil service retirement fund to help meet the cost of reimbursing the social security trust funds.

Expenditures in excess of income by the retirement system on account of the transfer-of-credit plan would be very small in the early years of operation of the plan, and would ultimately rise to a cost estimated to be about one-half of one percent of payroll subject to the civil service retirement system.

Under this financing method, active Federal employees who have monthly benefit protection under the civil service retirement system at the time they retire, become disabled, or die, would bear no part of the cost of the transfer-of-credit plan. The only cost of this plan to be borne by Federal employees would be the cost of social security contributions paid by those who separate after the effective date and, instead of receiving a full refund of their civil service retirement contributions as now, they would get their refund minus amounts equivalent to the social security contributions. In effect, they would be paying social security contributions and getting social security protection.

Employee representatives, practically unanimously, expressed concern that the cost in excess of the amounts withheld from refunds might eventually be charged, at least in part, to the employees covered by the retirement

system. One suggestion for forestalling this result was that the Government, as employer, reimburse the social security trust funds from general funds of the Treasury for that part of the cost of the transfer of credits which is in excess of the amounts withheld from refunds, presumably under a permanent indefinite authorization. Under this financing method the civil service retirement system would transfer to the social security trust funds annually the amounts withheld from refunds during the year, rather than, as in the method discussed above, retaining the withheld amounts until they are used, with other funds, to reimburse social security annually, on a proportionate basis, for the cost of social security benefits paid during the year.

Reverse transfer of credits not feasible

Consideration has been given to the idea of also transferring social security credits to the civil service retirement system. The intent would be to assure retirement credit for social security earnings and social security contributions in situations where the person has some social security credits but not enough to be insured for benefits. One of the problems that would result is if a Federal employee were assured of additional civil service credit whether he continued in his Federal employment or if he shifted to non-Federal employment, some of the Government's most competent and highly-trained employees might find this a further incentive to retire from Federal service while still at the peak of their productivity. Such persons might be able to get higher salaries and at the same time build up higher Federal staff-retirement benefits through employment outside of the Federal retirement system. 20/

Such a departure from the principle of relating civil service retirement system benefits to Federal employment might also raise questions of equity among many Federal employees. For example, some who have worked for many years at lower salaries than they could have earned elsewhere--an important consideration being that they counted Government contributions to their potential retirement benefits as part of their compensation--would find other Federal workers getting credit toward civil service retirement benefits based in part on work performed outside of the Federal civil service. The specific provisions of any such plan would have to be quite complex to avoid various types of anomalies. For example, an employee whose 29 years of work were all performed in the Federal service would not be eligible to retire under the civil service retirement system at age 55 while another

20/ When the President's Cabinet Committee on Federal Staff Retirement Systems reported in 1966 on, among other studies, its study of a proposal to provide civil service retirement system credits for non-Federal service (in this case, credit for service performed by State employees in programs supported wholly or in part by Federal funds), it said in part: "Precedents established by such action would inevitably lead to further broadening of creditable service categories, and the eventual complete degeneration of CSR as an effective instrument of Federal personnel management. In the process, substantial inequities among categories of employees would be generated." Source: Message From the President of the United States, 89th Congress, 2nd Session, House Document No. 402, March 7, 1966, page 42.

with fewer years of Federal service could presumably retire at age 55 if he had sufficient non-Federal work for which civil service retirement credit would be given. Also, a Federal employee with an annual salary from the Government of \$6,000 and social security credits in the same year of \$4,000 from non-Federal employment might get the same retirement credit as another employee with a Government salary of \$10,000.

Difficulties of these kinds would also arise, though to a lesser degree, if credits were transferred from social security to the civil service retirement system only in cases involving survivorship or disability benefits based on relatively short Federal service. However, it appears that the objectives of such a limited provision could be effectively achieved, and the difficulties avoided, through a combination of measures providing for transfer of Federal employment credits to social security when there is no eligibility for civil service benefits and a guaranteed minimum civil service benefit level where there is eligibility for civil service benefits.

Providing new benefits under the civil service retirement system to fill present gaps in protection

Representatives of several of the employee organizations have indicated some interest in the possibility of providing survivorship and disability benefits under the civil service retirement system for employees with less than 5 years' service, as a possible alternative to transferring credits to social security in such cases. We gave careful consideration to this possibility.

If there were little or no mobility of workers between Federal civil service employment and work covered by social security, such an approach would appear to be quite practicable and appropriate. However, in the face of the reality that every year hundreds of thousands of workers do move between Federal employment and other work, the approach appears to have serious disadvantages.

One disadvantage is that some of the gaps in protection would still be left unfilled. The many employees who, regardless of length of service, leave Federal service before retirement would continue to be left without survivorship or disability protection based on their Federal employment. Moreover, all who leave Federal service and obtain refunds of their contributions to the civil service retirement system (the great majority of those who leave) would get no retirement credit under any system for the years they worked in Federal employment.

It also appears that the cost to the civil service retirement system of this alternative approach would be higher than the cost of transferring credits to social security in the kinds of cases with which the alternative would deal. This would be true because under a transfer-of-credits plan the social security trust funds would bear part (in many instances, a large part) of the cost of the survivorship and disability benefits because many of the short-service Federal workers have had some previous work covered by social security. Under the alternative, in such cases the civil service retirement system and the employees involved would, presumably, have to bear the entire cost of the benefits.

b. Guaranteed minimum civil service benefits related to social security benefit levels

The guaranteed minimum annuity provision would be a liberalization of the civil service retirement provisions, and would not involve coordination with social security; the social security benefit levels are simply used as an appropriate standard of levels below which the amounts received by a beneficiary of the civil service retirement system should not fall.

Employees and their survivors who become entitled to benefits under the civil service retirement system would be guaranteed that the monthly benefit amounts under that system (or, if also eligible for social security benefits, from social security and the civil service retirement system combined) would be at least equal to the monthly amounts that would be payable if the Federal service had been covered under social security. ^{21/}

The guarantee provision would operate as illustrated in the following example: Assume that the surviving family of a Federal employee is eligible for a monthly benefit of \$200 under present provisions of the civil service retirement system and that, if the deceased worker's Federal employment had been covered under social security instead of under the civil service retirement system, the surviving family would have been eligible for social security benefits of \$400 a month. If the surviving family is not eligible for social security benefits based on any other employment which the deceased worker may have had, the civil service benefit amount would be \$400 a month under the guarantee rather than \$200 under present provisions. On the other hand, if in the same case the surviving family is eligible for an actual social security benefit of \$100 a month (based on work other than Federal employment), the \$100 social security benefit would be offset against the guaranteed amount (\$400), and so the civil service retirement system would pay \$300 a month. If, however, the actual social security benefit would reduce the civil service retirement benefit below the amount payable by the civil service retirement system under present law, the guarantee would not be applicable; the surviving family would receive the actual social security benefit amount and the civil service retirement benefit payable under present law.

Effect of the guarantee on protection

The guaranteed minimum annuity provision would have greatest impact on survivorship benefits, overcoming the shortcomings which in some situations occur in survivorship benefits paid under the civil service retirement system. Family survivorship protection would be improved even for many employees with 20 or more years of Federal service.

^{21/} If the guaranteed amounts under the minimum annuity provision were put into the civil service retirement law as a table, future increases in social security amounts would not automatically increase the amounts payable under the minimum guarantee; additional civil service legislation would be required to take future social security increases into account, and the effect upon the financing of the civil service retirement system could be given full consideration by the Congress.

The improvement in disability protection under this provision would mainly involve situations where an employee qualifies for a civil service disability annuity based on a relatively low high-5-year average pay. (In many situations, however, a civil service employee--particularly one with a family--who meets the social security definition of disability would find it quite advantageous to have his civil service credits transferred to social security and thus establish eligibility for social security disability benefits.) 22/

The guaranteed minimum annuity provision would rarely increase retirement benefit amounts payable under the civil service retirement system, since they are generally higher than what would be payable if the Federal service were covered under social security. Retirement benefits under social security can be higher than under the civil service retirement system in cases where the retiree had relatively short Federal service, but in such cases he will very likely qualify for substantial social security benefits based on other work, with the result that the guarantee would not increase the amount of the civil service retirement benefit.

The improved survivorship protection which would be provided in some situations under the guarantee is illustrated in the following table involving a Federal worker who has a wife and two children at the time he dies.

Table 6. Illustrative survivorship benefits payable under a guaranteed minimum annuity provision

Years of Federal Service	High-5-Year Average Salary Monthly	Average Earnings for Social Security Computation <u>1/</u> Monthly	Monthly CSR Survivor Benefit	
			Present Law	Minimum Guarantee
5	\$500	\$500	\$135	\$375
10	600	600	168	415
15	750	650	222	434
20	850	650	283	434

1/ \$7,800 (equivalent to \$650 a month) is the maximum creditable in a year for social security purposes under present law. It is assumed that the worker entered Federal employment at age 22.

22/ The U.S. Civil Service Commission has taken the position with respect to previous legislative proposals to provide a guaranteed minimum annuity that the guaranteed amount should not in effect create new classes of beneficiaries under the civil service retirement system. In practice, this would exclude from the guaranteed amount in a disability or retirement case any benefit amounts for family dependents since the civil service retirement system does not pay benefits to dependents of retirees. In the interest of administrative simplicity, the Civil Service Commission would also compute the guaranteed amount on the basis of high-5-average salary rather than the generally lower average monthly wage computed over a longer period under social security.

Cost of providing the guarantee

Since the guarantee provision would simply be a liberalization of benefits provided by the civil service retirement system, the cost would be entirely an added cost to that system. While the cost of the guarantee would of course be affected by the specific provisions adopted, it is estimated that the total "normal" cost would be less than one-half of one percent of civil service payroll.

c. Medicare for Federal employees

It appears that a sound approach to providing an appropriate relationship between the FEHB and Medicare programs should be one aimed at: (a) eliminating duplications in coverage under the two programs; (b) assuring for all Federal civil service employees and retirees at age 65 a continuation of the high-quality health insurance protection they have under the FEHB program; and (c) providing such protection at a low cost appropriate to their reduced income in retirement.

A plan for relating the FEHB program to Medicare

The key provisions in this approach would be the following:

- (1) Federal workers whose Government employment is not covered under the general social security provisions would have their employment covered under the hospital insurance provisions of social security for purposes of becoming insured for Part A (hospital insurance) Medicare protection when they reach age 65.
- (2) Civil service retirees who reach age 65 before their employment has been covered under the hospital insurance provisions long enough for them to become insured would be deemed insured under Part A of Medicare. The cost of deeming these retirees to be insured would be borne by the Government, as employer.
- (3) All civil service retirees would, as now, have the option to enroll under Part B (supplementary medical insurance) of Medicare.
- (4) Health insurance designed to complement Medicare would be made available under the FEHB program to Federal retirees and employees who become entitled to Part A protection. This complementary insurance would, together with Part A and Part B protection under Medicare, provide health insurance protection at approximately the level provided under the Government-wide high-option FEHB plans. The cost of this complementary health insurance might be met wholly by the Federal Government or part of the cost might be left to be borne by employees. If the whole cost were met by the Federal Government, there would be assurance that all retirees had this protection. Also, if the cost were borne wholly or even largely by the Federal Government the result would be that retirees would have a considerably larger percentage of the cost of their Federal employee health

benefits borne by the Federal Government than is now the case. At present, retirees who have coverage under high-option plans pay about two-thirds of the cost of their health insurance, while the Federal Government pays only about one-third of the cost.

Workers in Federal employment that is excluded from social security coverage would be covered under the Part A provisions of Medicare. The Federal employees and the employing agencies would then make contributions (now 0.6 percent of pay up to \$7,800) toward Part A protection, like other employees (and their employers) whose jobs are covered under social security. When the workers (and their spouses) reach age 65, they would be insured for Part A benefits if they have credits for enough quarters of coverage to meet the social security insured-status requirement for retirement. For the purpose of determining insured status, the new Part A credits would be counted in the same way as full social security credits.

A provision for deeming insured under Part A of Medicare those who reach age 65 before having become insured through covered work seems warranted in the interest of making the plan fully effective at the outset. Those for whom Part A protection would be provided in this way would include retirees and employees, their spouses at age 65, and the surviving spouses at age 65 of deceased annuitants and employees who died in service. The group would also include employees who are in Federal employment subject to coverage under Part A of Medicare and who do not work long enough before retirement to meet the insured-status requirement.

This transitional provision would be somewhat comparable to a special transitional provision included in the Medicare legislation in 1965. Under that provision, coverage under Part A of Medicare was provided for people who reached age 65 before 1968 and were not eligible on the basis of covered work. The cost of benefits provided under the 1965 transitional provision is paid from general Treasury revenues. Although some Federal annuitants were "blanketed-in" for protection under the 1965 provision, about 175,000 retiring after June 1960 were excluded. Some employee representatives feel that the exclusion of many Federal retirees from the transitional insured status provisions of Medicare has been unfair and has caused hardships for the employees, including employees who retired while young on account of disability before 1960 and were not yet 65 years old in 1968.

Coverage under present Federal employee health benefit plans would be terminated for those who become entitled to Part A protection but the Federal Government, as employer, would make available health benefits coverage designed to complement Part A and Part B of Medicare in a way which would maintain the health insurance protection of employees and annuitants at the general high-option level of the present FEHB plans. The new complementary insurance should make provisions for continued protection of spouses not old enough to be eligible for Medicare where the retiree becomes eligible and for the relatively few dependent children of retirees eligible for Medicare. Some representatives of employee organizations were emphatic that any plan of this kind should assure continuing protection of younger family members.

Advantages of the proposed plan

Adoption of the approach outlined here would assure practically all Federal employees of relatively low-cost health insurance protection after age 65. With Part A (of Medicare) protection assured, and a new complementary FEHB plan available, there would be greater advantage than is now the case for Federal retirees in subscribing for Part B protection. This is because there would no longer be present the barrier to Part B enrollment that now results from the overlapping of Part B benefits and those under the FEHB plans. By reason of such overlapping Federal retirees now enrolled in Part B get less protection for their premium dollars than do other enrollees.

This approach has the advantage inherent in the prepayment principle--that is, the worker would contribute, with his employer, while he is working, towards the cost of his health insurance after age 65. Also, it would assure that people whose working lifetimes are divided between Federal and other employment would contribute towards Part A protection throughout their working lifetimes, as in the case of practically all other workers.

Though this approach would of course have no effect on the civil service retirement system--the FEHB program being entirely separate from that system--the present situation is in many respects analogous to the situation that existed between the civil service retirement system and social security some years ago before the two systems proceeded on a long course of independent development, which made coverage-coordination of the two systems increasingly difficult. Because the Medicare and FEHB programs are still relatively new, the time is opportune to establish an appropriate coordination between them; this will very likely become more difficult in the future as the two programs develop independently.

Cost implications

Estimates of the specific cost effects of this approach would require extensive analysis to develop projections of future costs of the FEHB program (taking into account increasing health care costs and the increasing proportion of aged persons covered), to determine the extent to which the amount of contributions that would be made to Part A of Medicare by employees and the Government would be offset by reductions in FEHB costs, and to evaluate such other interacting factors as the effect of greatly increased participation of Federal retirees in Part B of Medicare.

The approach would of course improve the health benefits protection of a minority of older Federal employees and annuitants who do not now subscribe to the high-option FEHB plans, and so would result in a moderate increase in over-all costs, although the main thrust of the plan is to redistribute the financing of the high-level protection now maintained by most of the older employees and annuitants, so as to reduce the cost to the individuals when they have lower incomes in retirement.

Because a major part of the present FEHB cost of providing health insurance protection for the high-cost elderly members would be met through their coverage under the Medicare program, it is clear that there would be a significant reduction in the rate of increase in the over-all cost of the FEHB program, and this would, in effect, produce savings in FEHB premium rates for Federal employees that would be an offset against the cost of their contributions toward Part A coverage of their employment. The contributions that the Government as employer makes to the present FEHB plans for the protection of elderly members could be used toward the financing of the new complementary FEHB plan. Under this approach, the Government, as employer, would be paying a substantially larger proportion of the health benefits protection of retirees who have reached age 65, than under the present arrangement.

3. The question of special limitations on social security benefits payable to persons also receiving substantial civil service retirement benefits.

Consideration of whether or not any special limitations should be placed on the heavily-weighted social security benefit amounts of certain Federal retirees who also receive substantial civil service benefits raises a number of difficult questions. These include:

Can an effective solution be devised which would avoid the creation of other anomalies and inequities such as the provision of lower benefit amounts than are provided in present law, or imposition of the special limitations on people already getting social security benefits or on those already insured but not getting benefits?

Can an equitable test be devised (e.g., length of Government service, level of Government pay) to determine whether a retired employee should be subject to special limitations on social security benefits?

How would equitable treatment be provided among the several categories of annuitants who are in a similar position with respect to social security benefits, such as annuitants of the Federal civil service, annuitants of State and local government retirement systems, and annuitants of the railroad retirement system?

The situation which occurs when Federal retirees receiving substantial civil service retirement benefits also receive heavily-weighted social security benefits cannot appropriately be changed by simply reducing social security benefit amounts of such retirees to remove the weighting. Such an approach would reduce benefits below what is provided in present law for people who retire after a given date while those who retire before the date continue to receive the heavily-weighted benefits even though they have similar work histories. Further, this inequity would become even more pronounced at the time of general benefit increases in the future because the same percentage increase applied to the weighted benefit and the unweighted benefit would widen the difference between them.

Elimination of this inequity by reducing the benefits of those already on the rolls below the present-law level also seems infeasible. Even if social security benefits were reduced below the present-law level for only people who retire in the future, it would still be unfair to people who became insured for social security benefits through work performed in the past to reduce the benefit amounts which they had every reason to believe would be payable under present law.

We gave some consideration to a possibility under which present minimum social security benefits would be maintained at present levels for persons eligible for public retirement-system annuities based on substantial salary, in the event that social security benefits are generally increased in the future. In such cases, the present minimum benefit of \$55 a month would continue to be payable, and close-to-minimum benefits would be increased only enough to blend them into the range of higher benefits. 23/

This approach would also involve some difficult problems. One of the most difficult is that of defining equitably the group getting "substantial" staff-retirement benefits and therefore subject to the special limitations on social security benefits. Such benefits could be considered to mean benefits based on, say, 35 or more years of public employment not covered under social security, and a final salary equivalent to or greater than the top step of grade 6 in the General Schedule of the Federal civil service retirement system--now \$8,221 a year. Such a provision would affect only those public annuitants who have worked relatively short periods of time under social security or have only marginal earnings under the program.

If people with 30 or more years of public employment were included, it would seem necessary to provide some sort of sliding scale of special benefit levels applicable to retirees with 30 to 34 years of public employment. This would further complicate the provision but would avoid a sharp drop in benefit amounts between those who have 35 years of Government service and those who have, say, 34 years of service. While persons with less than 30 years of Government employment could also be included, a larger proportion of the people affected would be people whose total retirement benefits represent only a very modest replacement of earnings. 24/

A possible alternative would be to make the described approach applicable only to people who become insured under social security in the future. As noted earlier, however, the cases in which minimum or near-minimum social security benefits are based on very little coverage are mainly among people who are already on the benefit rolls.

23/ An illustration following this approach is described in Appendix H.

24/ Data in the current study of Federal annuitants referred to previously indicate that Federal annuitants who retired under the "optional 12-29 years of service" provisions of civil service retirement with high-5 averages equivalent to average Federal salaries today and workers' basic benefit amounts of \$55 to \$85 number only 4% of all Federal annuitants.

If, despite the new problems that would be created, the described approach or a similar one should be considered, it clearly would be discriminatory to limit it to Federal employees. It would, in equity, have to be made applicable to State and local government employees receiving staff-retirement system benefits based on public employment not covered under social security. Obviously, the pattern of employment which may result in a minimum or near-minimum social security benefit exists with respect to all public employment not covered by social security. It would appear that consideration would also have to be given to whether or not employment under the railroad retirement system should be included under the benefit limitation provisions. Others who receive minimum or near-minimum social security benefits are those who for any reason work for a comparatively short time in work covered under social security, such as employees of some nonprofit organizations.

A broad approach to the question of the heavily-weighted benefits based on relatively short social security coverage could be developed if, in the future, consideration is given to very substantially raising the minimum benefits, say, to \$100 or more. Provisions could then be considered that would assure that only persons with reasonably long periods of covered work at low pay would receive the higher minimum benefit. It seems reasonable to think that, if any solution is required with respect to the relatively small number of civil service annuitants who are also getting social security benefits and whose combined retirement benefits may be regarded as excessive, it should be in the context of a broader solution for all people who may in the future become entitled to very substantial minimum benefits under social security.

CONCLUSIONS AND RECOMMENDATIONS

1. Extending social security coverage to employment subject to the Federal civil service retirement system would be more likely than other approaches to assure that the combined benefits (and contributions) of people who move between work covered by social security and the civil service retirement system would be at a planned and systematic level. However, the liberalization and independent development of the civil service retirement and social security systems over a long period of time present formidable obstacles to the adoption of the coverage approach. To deal effectively with the existing gaps and shortcomings in protection, the extension of coverage would have to be on an essentially compulsory basis; to avoid excessive costs and combined benefit amounts that could be regarded as unduly large, a coverage plan would have to provide for substantial reductions in the benefits of the civil service retirement system to take into account that social security benefits would be payable. Even a workable coverage plan providing for reductions in civil service retirement benefits would be quite costly, in part because of increases which would be required in some benefit levels, not needed to fill gaps or deficiencies, in order to avoid deliberalization of benefits for some employees.
2. Some of the organizations of Federal employees favor social security coverage of employment subject to the civil service retirement system, but only on a basis of individual choice and with no reduction of benefits of the civil service retirement system. Proposals to provide individual voluntary coverage under social security have been considered from time to time by the Committee on Ways and Means and the Committee on Finance, by the Executive Branch of the Government, and by a number of social security advisory councils consisting of experts from all major parts of the economy. It was always concluded that social security coverage on an individual voluntary basis is undesirable. Voluntary coverage would not fill the gaps in protection because many of those most needing social security protection would not elect coverage, and the increased cost to the Government would largely go toward enhancing the benefits of those employees who are best able to afford the social security contributions, sometimes to levels exceeding earnings before retirement. Further, the adverse selection of coverage would increase the costs of the social security program at the expense of other workers who are covered on a compulsory basis.
3. In view of the obstacles to the establishment of an acceptable coverage plan, we considered alternative measures that might largely deal with the matters indicated in the Committees' request--the gaps and deficiencies in the cash benefit protection of workers who have Federal employment, the lack of a satisfactory relationship between Medicare and the Federal employees health benefits program, and the situation in which some annuitants of Government retirement systems also qualify for the heavily-weighted minimum or near-minimum social security benefits and thus derive an advantage not intended for higher-paid workers. We have reviewed previously advanced proposals intended to solve these problems and we have also explored other possibilities. On the basis of our study we recommend that the Congress consider the following related measures as an effective and less costly alternative to

direct social security coverage of employment subject to the civil service retirement system.

(a) Transfer of credits to social security:

Where there is no benefit eligibility under the civil service, foreign service, or Central Intelligence Agency retirement system when a worker dies, becomes disabled, or retires, credits would be transferred from the staff retirement system to social security. The social security trust funds would be reimbursed for the proportionate cost of benefits attributable to the transferred credits with part of this reimbursement financed through withholding by the civil service retirement system of amounts equivalent to social security employee contributions from refunds made to separating employees or their survivors.

(b) Guaranteed minimum civil service benefits:

Where there is benefit eligibility under the civil service, foreign service, or Central Intelligence Agency retirement system, the staff retirement system benefits (or if social security benefits based on other work are also payable, the staff retirement system and social security benefits together) would be guaranteed to be at least as high as if employment subject to the staff retirement system had been covered by social security.

(c) Medicare coverage for Federal employment:

Federal workers whose Government employment is not covered under the general social security provisions would have their employment covered under the hospital insurance provisions of social security for purposes of becoming insured for Part A (hospital insurance) Medicare protection when they reach age 65. Those present civil service retirees who are not insured under social security, and their spouses, would at age 65 be deemed insured under Part A of Medicare and could then advantageously enroll under Part B (supplementary medical insurance); the cost of the Part A protection would be borne by the Government, as employer. New health insurance designed to complement Medicare would be available under the FEHB program to Federal retirees and employees who become entitled to Part A protection. This complementary insurance would, together with Part A and Part B protection under Medicare, provide health insurance protection at approximately the level provided under the Government-wide high-option FEHB plans.

4. The number of people who qualify for minimum or near-minimum social security benefits and also for Government retirement-system annuities based on substantial salary was found to be much smaller than might have been anticipated. The number of such cases will decline in the future; as time passes, longer periods of social security coverage will be required to become insured for benefits, and benefit amounts based on substantial periods of social security coverage will generally be above the levels at which the heaviest weighting occurs. We believe that any legislative change designed to eliminate such cases would give rise to inequities as between some of the

people who would get reduced benefits and some who would get unreduced benefits. 25/

We recommend against any legislative action to provide for reduction of social security benefits paid to Government employees. We suggest, however, that a broad approach, going beyond Government retirees, be considered if, at some future time, the Congress should contemplate very substantially raising the minimum benefits, say, to \$100 or more. Provisions could then be considered that would assure that only people with reasonably long periods of covered work at low pay would receive the increased minimum benefits.

* * * * *

The three measures we propose would assure that workers subject to the civil service, foreign service, or Central Intelligence Agency retirement system, though not directly covered under social security, would nevertheless have protection under social security or at least the equivalent of such protection under the staff-retirement system. Employees would have the assurance that if they leave Federal service and lose protection under their staff-retirement system their Federal employment will be credited under social security, giving them the same continuity of basic protection that is afforded workers who move from one job to another in private industry. Such employees would get credit for all, not just some, of their years of work. Career employees and their families would be afforded greatly improved survivorship protection before they have completed long periods of service, and some would have improved disability protection as well. An appropriate and workable relationship would be established between Medicare and the Federal employees health benefits program. All Federal employees would be assured that at age 65 they would have low-cost health insurance protection.

While we do not at this time have definitive cost estimates on the additional costs that would result from adoption of the above-described proposals, it is clear that the costs would be very substantially below the cost of a workable coverage-coordination plan.

We believe that these measures, taken together, would effectively remedy the shortcomings and inequities in the existing protection of workers who have Federal employment that were noted in the Committees' request. They would achieve this objective without incurring nonessential costs or making any changes in the Federal staff-retirement systems that would be inconsistent with their basic purposes or interfere with their continued independence.

25/ Among the many approaches we considered in the course of our study, the approach described in Appendix H seemed the least fraught with possibilities for creating new problems.

APPENDIXES

Table of Contents

- Appendix A. Comparison of the principal benefit provisions of the civil service, foreign service, and Central Intelligence Agency retirement systems, and of social security.
- Appendix B. Examples of monthly benefit payments under the civil service retirement system.
- Appendix C. Examples of monthly benefit payments under social security.
- Appendix D. (a) Employee and Government premium rates of the Government-wide Federal employees health benefits plans.

(b) Benefit experience by patient category under high-option Federal employees health benefits plans authorized by the FEHB Act of 1959.
- Appendix E. Comparison of major benefits under the Government-wide service benefits plan (high option) of the Federal employees health benefits program and the Medicare program (as of 1/1/69.)
- Appendix F. Selected material from earlier reports on social security and Federal employment.
- Appendix G. Illustrative monthly benefits payable under a transfer-of-credit plan.
- Appendix H. Illustrative method for reducing social security amounts of public employees who also receive substantial staff-retirement system benefits.

APPENDIX A

Comparison of the principal benefit provisions of the civil service, foreign service, and Central Intelligence Agency retirement systems, and of social security

Provisions	Civil Service 1/	Foreign Service	Central Intelligence Agency	Social Security																																																																								
A. Financing																																																																												
Contributions	Employee and agency each contribute 6 1/2% of basic pay.	Same as CSR	Same as CSR	Contributions, on annual earnings base of \$7800, are-- Employee & employer each for OASDI and Medicare hospital insurance (HI): <table><tr><th>Calendar Year</th><th colspan="3">Percent</th></tr><tr><td></td><th>OASDI</th><th>HI</th><th>Total</th></tr><tr><td>1968</td><td>3.80</td><td>.60</td><td>4.40</td></tr><tr><td>1969-70</td><td>4.20</td><td>.60</td><td>4.80</td></tr><tr><td>1971-72</td><td>4.60</td><td>.60</td><td>5.20</td></tr><tr><td>1973-75</td><td>5.00</td><td>.65</td><td>5.65</td></tr><tr><td>1976-79</td><td>5.00</td><td>.70</td><td>5.70</td></tr><tr><td>1980-86</td><td>5.00</td><td>.80</td><td>5.80</td></tr><tr><td>1987 on</td><td>5.00</td><td>.90</td><td>5.90</td></tr></table> Self-employed persons: <table><tr><th>Calendar Year</th><th colspan="3">Percent</th></tr><tr><td></td><th>OASDI</th><th>HI</th><th>Total</th></tr><tr><td>1968</td><td>5.80</td><td>.60</td><td>6.40</td></tr><tr><td>1969-70</td><td>6.30</td><td>.60</td><td>6.90</td></tr><tr><td>1971-72</td><td>6.90</td><td>.60</td><td>7.50</td></tr><tr><td>1973-75</td><td>7.00</td><td>.65</td><td>7.65</td></tr><tr><td>1976-79</td><td>7.00</td><td>.70</td><td>7.70</td></tr><tr><td>1980-86</td><td>7.00</td><td>.80</td><td>7.80</td></tr><tr><td>1987 on</td><td>7.00</td><td>.90</td><td>7.90</td></tr></table>	Calendar Year	Percent				OASDI	HI	Total	1968	3.80	.60	4.40	1969-70	4.20	.60	4.80	1971-72	4.60	.60	5.20	1973-75	5.00	.65	5.65	1976-79	5.00	.70	5.70	1980-86	5.00	.80	5.80	1987 on	5.00	.90	5.90	Calendar Year	Percent				OASDI	HI	Total	1968	5.80	.60	6.40	1969-70	6.30	.60	6.90	1971-72	6.90	.60	7.50	1973-75	7.00	.65	7.65	1976-79	7.00	.70	7.70	1980-86	7.00	.80	7.80	1987 on	7.00	.90	7.90
Calendar Year	Percent																																																																											
	OASDI	HI	Total																																																																									
1968	3.80	.60	4.40																																																																									
1969-70	4.20	.60	4.80																																																																									
1971-72	4.60	.60	5.20																																																																									
1973-75	5.00	.65	5.65																																																																									
1976-79	5.00	.70	5.70																																																																									
1980-86	5.00	.80	5.80																																																																									
1987 on	5.00	.90	5.90																																																																									
Calendar Year	Percent																																																																											
	OASDI	HI	Total																																																																									
1968	5.80	.60	6.40																																																																									
1969-70	6.30	.60	6.90																																																																									
1971-72	6.90	.60	7.50																																																																									
1973-75	7.00	.65	7.65																																																																									
1976-79	7.00	.70	7.70																																																																									
1980-86	7.00	.80	7.80																																																																									
1987 on	7.00	.90	7.90																																																																									

Provisions	Civil Service	Foreign Service	Central Intelligence Agency	Social Security
B. Age and service retirement	<p>Full benefits at age 62 after 5 years, age 60 after 20 years²/or age 55 after 30 years: 1 1/2% of average salary of highest 5 consecutive years times years of service not exceeding 5, plus 1 3/4% of high-5 average salary times years of service exceeding 5 but not exceeding 10, plus 2% of high-5 average salary times years of service exceeding 10. Substitute 1% of high-5 salary, plus \$25 for any or all of above percentages if higher. Maximum: 80% of high-5 average salary.</p>	<p>Full benefits at age 50 after 20 years: 2/2% of high-5 year average salary for which full contributions have been made times years of service not exceeding 35. Maximum: 70% of high-5 average salary.</p>	<p>Full benefits at age 50 after 20 years of service provided 10 years service with Agency, at least 5 of which was in certain service designated by the Director of CIA as being subject to this retirement system. Computation same as in foreign service system.</p>	<p>At age 62 (reduced if benefits taken before age 65) with fully insured status. A person is fully insured if he has 40 QC's or has at least 6 QC's and has at least 1 QC (acquired at any time) for every year elapsed after 1950, or age 21, if later, and before age 65 for men or age 62 for women, or year of death or disability if earlier. Retirement benefit is equal to the primary insurance amount (PIA) which is computed from a benefit table that is based approximately on the formula: 71.16% of the first \$110 of average monthly wage; 3/ plus 25.88% of the next \$290; plus 24.18% of the next \$150; plus 28.43% of the next \$100. Minimum: \$55.00 Maximum: 218.00</p>

Provisions	Civil Service	Foreign Service	Central Intelligence Agency	Social Security
C. Disability provisions	<p>After 5 years: Disabled for position held, same as age and service retirement unless higher benefit allowable under guaranteed minimum formula which grants lesser of (1) 40% of high-5 average salary or (2) annuity computed under general formula after adding assumed service from date of separation to age 60.</p>	<p>After 5 years: Disabled for position held, same as age and service retirement unless higher benefit allowable under guaranteed minimum formula which grants lesser of (1) 40% of high-5 average salary or (2) annuity computed under regular formula after adding assumed service from date of separation to mandatory retirement age for class held at retirement.</p>	Same as CSR	<p>At any age before 65, after a 6-month waiting period. The worker must be unable to engage in any substantial gainful activity; the impairment must be a medically determinable physical or mental condition that is expected to continue for at least 12 months or to result in death. Fully insured status and (a) if disabled before age 24, at least 6 QC's out of the 12 quarters preceding disablement, or (b) if disabled between ages 24 and 31, QC's in at least half of the quarters after age 21, or (c) if disabled after age 31, 20 QC's in the 40-quarter period ending with disablement. Benefit is equal to the PIA.</p>

Provisions	Civil Service	Foreign Service	Central Intelligence Agency	Social Security
D. Dependents of annuitants	No provision	No provision	No provision	Wife, or dependent husband, age 62 or over (reduced if taken before age 65), or wife caring for a child entitled to benefits, and dependent, unmarried child, if child is under age 18 (or 22 if full-time student), or disabled with a disability which began before age 18, of a person entitled to retirement or disability benefits. Benefit is 50% of PIA except that benefit for wife or dependent husband may not exceed \$105, subject to maximum family benefit. Maximum family benefit is computed from a benefit table that is based approximately on formula: 80% of first \$436 of average monthly wage, 40% of next \$214 of average monthly wage, but not less than 1 1/2 times PIA.

Provisions	Civil Service	Foreign Service	Central Intelligence Agency	Social Security
<p>E. Survivor provisions</p> <p>1. Annuities or benefits</p>	<p>Death before retirement-- After 5 years: Widow, disabled dependent widower, and unmarried children under age 18 (or 22 if full-time student), or if older, incapable of self-support because of a disability incurred before age 18: $\frac{5}{55}$ of regular worker's annuity plus for each child the smallest of (1) 40% of high-5 average salary divided by number of children. (2) \$687, or (3) \$2061 divided by number of children. Children with no surviving parent: to each child the smallest of (1) 50% of employee's high-5 average salary divided by number of children, (2) \$824.40, or (3) \$2,473.20 divided by number of children.</p>	<p>Death before retirement-- After 5 years: Widow, disabled dependent widower, and unmarried children under age 18, or disabled with a disability which began before age 18: $\frac{5}{50}$ of disability annuity computed as described in (C) above plus for each child the smallest of-- (1) 40% of employee's high-5 average salary divided by number of children, (2) \$661.80, or (3) \$1985.40 divided by number of children. Children with no surviving parent: to each child the smallest of-- (1) 50% of employee's high-5 average salary divided by number of children, (2) \$794.16, or (3) \$2382.48 divided by number of children.</p>	<p>Same as CSR, except unmarried children under age 21 if full-time student, and disabled widower who received at least $\frac{1}{2}$ support from deceased employee.</p>	<p>Widow age 60 or over (benefits reduced if taken before age 62), or between age 50 and 60 and disabled; widow (mother), if caring for a child under age 18 or disabled who is entitled to benefits; dependent widower, age 62 or over, or between age 50 and 62 and disabled; dependent parent, age 62 or over, dependent unmarried child under age 18 (or 22 if full-time student), or disabled with a disability which began before age 18. Fully insured status required except that child's and mother's benefits may also be paid based on currently insured status. Currently insured status requires 6 quarters of coverage within the 13-quarter period ending with the quarter of death. Benefit for widow, dependent widower, or dependent parent is $82\frac{1}{2}\%$ of PIA, except that 2 dependent parents receive 75% each. Benefit for child and mother is 75% of PIA. All benefits subject to maximum family benefit provisions.</p>

Provisions	Civil Service	Foreign Service	Central Intelligence Agency	Social Security
2. Optional annuities	Death after retirement-- Children--Same as provisions for death before retirement.	Death after retirement-- Children--Same as provisions for death before retirement.	Same as CSR	No distinction based on whether death occurred before or after retirement.
	Death after retirement-- Widow or widower: if named at retirement, with reduced annuity, entitled to 55% of amount of service annuity elected as survivor base. Person with insurable interest: Beneficiary named by unmarried employee or member in good health at retirement, entitled to 55% of reduced service annuity.	Death after retirement-- Widow or widower: If named at retirement, with reduced annuity entitled to 50% of service annuity elected as survivor base. To other beneficiaries named by unmarried employee in good health at retirement 50% of employee's reduced service annuity.	Same as CSR	No provision

Provisions	Civil Service	Foreign Service	Central Intelligence Agency	Social Security
3. Lump Sum	<p>Death before retirement-- Death in service: Less than 5 years--refund of accumulated contributions, plus interest (if at least 1 year) to death. If more than 5 years and no survivor annuitant, refund with interest only to 12/31/56. Death after separation: Less than 5 years, refund with interest (if at least 1 yr) to separation. Over 5 years, refund with interest to 12/31/56. Termination of annuity rights: For survivors before exhaustion of lump-sum credit, refund plus interest to 12/31/56, less all regular annuities paid.</p> <p>Death after retirement-- Death before exhaustion of lump-sum credit and no survivor or termination of annuity rights for survivors prior to exhaustion of lump-sum credit: Refund, plus interest to 12/31/56, less all regular annuities paid.</p>	<p>Death before retirement-- Death in service: Less than 5 years or more than 5 years and no survivor annuitant, refund plus interest to date of death. Death before age 60 after separation with entitlement to deferred annuity except after selection--out from FSO Class 4 or 5; refund with interest to date of separation. Termination of annuity rights: For survivors before exhaustion of lump-sum credit, refund plus interest to date of separation, less all regular annuities paid.</p> <p>Death after retirement-- Death before exhaustion of lump-sum credit and no survivor, or termination of annuity rights for survivors prior to exhaustion of lump-sum credit: Refund, plus interest to date of separation, less all regular annuities paid.</p>	Same as CSR	Payable based on fully or currently insured status. Benefit is 3 times PIA with \$255 maximum.

Provisions	Civil Service	Foreign Service	Central Intelligence Agency	Social Security
F. Separation provisions	<p>One year or less: Refund without interest.</p> <p>More than 1 year, but less than 5 years: Refund with interest to separation. After 5 years: (a) Deferred annuity at age 62, or (b) refund, with interest to 12/31/56, provided application filed more than 31 days before commencing date of any annuity for which he may be eligible. If separation is involuntary, after 25 years, or after 20 years at age 50, immediate annuity reduced by 1/6 of 1% for each month the employee is under age 55.</p>	<p>Less than 5 years: Refund with interest to date of separation. After 5: Deferred annuity at age 60, or refund with interest to date of separation provided application for refund filed prior to attaining eligibility for an annuity. If separation is by selection-out from FSO Classes 4, 5, 6, or 7: 1/12 of year's salary at current salary rate for each year of creditable service with maximum of one year's salary plus deferred annuity at age 60 or refund of contributions plus interest as described above.</p>	<p>Same as CSR. <u>6</u></p> <p>Involuntary separation--same as CSR, except computation of benefits is same as in foreign service system.</p>	None
G. Cost-of-Living annuity increase provision	<p>When Consumer Price Index is up at least 3% for 3 consecutive months, annuity is increased by percentage of rise in CPI, effective the first day of the third calendar month following the third month of the increase, for annuity that commenced before the effective date.</p>	<p>Effective April 1 after any year in which Consumer Price Index has been up at least 3%, annuity increased by rise in CPI, for annuity that commenced before January 2 of the year in which the CPI increase occurred.</p>	Same as CSR.	None.

Footnotes:

- 1/Provisions also generally apply to Members of Congress except Members contribute 7 1/2% of basic pay and are eligible for full benefits computed at 2 1/2% of high-5-average salary times years of service at age 62 after 5 years, or age 60 after 10 years; annuities of certain congressional employees are also computed under a special benefit formula.
- 2/Employee mandatorily separated under civil service system after attaining age 70 with 15 years' service and under foreign service system at age 60 (except career ministers and ambassadors).
- 3/Average monthly wage is based on earnings in a specified number of years. Generally, the number of years is 5 less than the number elapsing after 1950 (or after age 21, if later) and up to the year in which the worker reached age 65 (age 62 for women), became disabled, or died; the years used in the average are those after 1950 in which earnings were highest.
- 4/Under special transitional provisions monthly benefits are payable at age 72 or over to certain workers, wives, and widows on the basis of fewer quarters of coverage; the amount is \$40 for workers and widows and \$20 for wives.
- 5/Although cost-of-living increases of annuities generally apply only with respect to annuitants already on the rolls, cost-of-living adjustments permanently modify annuity rates for a child, since a child's benefit is a specified amount not affected by salary increases. Child annuity amounts under CSR are to be raised at least 3.7% effective March 1969, and under foreign service effective April 1969.
- 6/If separation is involuntary, retirement at any age with 25 years of service or at age 50 with 20 years (provided 10 years of service with Agency, at least 5 years of which was in certain service designated by the Director of the CIA as being subject to the CIA retirement system).

APPENDIX B

Examples of monthly benefit payments under the civil service retirement system

(a) Age-service retirement benefits payable to a retired worker and his widow

	High-5-Average Salary						
	\$5, 000	\$7, 000	\$8, 000	\$9, 000	\$10, 000	\$12, 000	\$14, 000
Retirement after 20 years of service -if maximum survivor benefit is provided for wife -maximum survivor benefit for widow	\$151 147 83	\$211 206 116	\$242 236 133	\$272 265 150	\$302 294 166	\$363 349 200	\$423 403 233
Retirement after 30 years of service -if maximum survivor benefit is provided for wife -maximum survivor benefit for widow	234 229 129	328 318 180	375 360 206	422 402 232	469 444 258	563 529 310	656 613 361
Retirement after 42 years of service (maximum benefit) -if maximum survivor benefit is provided for wife -maximum survivor benefit for widow	333 323 183	467 443 257	533 503 293	600 563 330	667 623 367	800 743 440	933 863 513

(b) Minimum monthly benefits payable to a disabled worker^{1/} (Disability benefit amounts are equivalent to age-service retirement benefit amounts if the disabled worker had at least 21 years and 11 months of covered Federal service.)

	High-5-Average Salary						
	\$5, 000	\$7, 000	\$8, 000	\$9, 000	\$10, 000	\$12, 000	\$14, 000
40% minimum guarantee	\$167	\$233	\$267	\$300	\$333	\$400	\$467
Guaranteed benefit based on years of service plus years to age 60 at time of disablement 10 years total	68	95	108	122	135	163	190
15 years total	109	153	175	197	219	263	306
20 years total	151	211	242	272	302	363	423

^{1/}The civil service retirement system guarantees that the annuity of an employee who qualifies for disability retirement will be no less than the smaller of the two following amounts: (a) 40 percent of the employee's "high-5" average salary, or (b) the amount obtained under the general formula after increasing the employee's actual service by the time remaining between the date of his separation and the date he attains age 60. (However, only the disabled employee's "earned" annuity may be used as a base for the survivor benefit.)

(c) Benefits payable to widows and surviving children in the case of a worker who dies in service

	High-5-Average Salary					
	\$5, 000	\$7, 000	\$8, 000	\$9, 000	\$10, 000	\$14, 000
Widow of worker who had 5 years' service -widow and 1 child -widow and 2 children	\$ 17 74 131	\$ 24 81 138	\$ 28 85 142	\$ 31 88 145	\$ 34 91 148	\$ 41 98 155 \$ 48 105 162
Widow of worker who had 10 years' service -widow and 1 child -widow and 2 children	37 94 151	52 109 166	60 117 174	67 124 181	74 131 188	89 146 203 104 161 218
Widow of worker who had 20 years' service -widow and 1 child -widow and 2 children	83 140 197	116 173 230	133 190 247	150 207 264	166 223 280	199 256 313 233 290 347
Widow of worker who had 30 years' service -widow and 1 child -widow and 2 children	129 186 243	180 237 294	206 263 320	232 289 346	258 315 372	309 366 423 361 418 475
Child with no living parent	69	69	69	69	69	69

APPENDIX C

Examples of Monthly Benefit Payments Under Social Security

Average yearly earnings after 1950 ^{1/}	\$899 or less	\$1800	\$3000	\$4200	\$5400	\$6600	\$7800
Retired worker--65 or older) Disabled worker--under 65)	55.00	88.40	115.00	140.40	165.00	189.90	218.00
Wife 65 or older	27.50	44.20	57.50	70.20	82.50	95.00	105.00
Retired worker at 62	44.00	70.80	92.00	112.40	132.00	152.00	174.40
Wife at 62, no child	20.70	33.20	43.20	52.70	61.90	71.30	78.80
Widow at 62 or older	55.00	73.00	94.90	115.90	136.20	156.70	179.90
Widow at 60, no child	47.70	63.30	82.30	100.50	118.10	135.90	156.00
Disabled widow at 50, no child	33.40	44.30	57.60	70.30	82.70	95.10	109.20
Wife under 65 and one child	27.50	44.20	87.40	140.40	165.00	190.00	214.00
Widow under 62 and one child	82.50	132.60	172.60	210.60	247.60	285.00	327.00
Widow under 62 and two children	82.50	132.60	202.40	280.80	354.40	395.60	434.40
One child of retired or disabled worker	27.50	44.20	57.50	70.20	82.50	95.00	109.00
One surviving child	55.00	66.30	86.30	105.30	123.80	142.50	163.50
Maximum family payment	82.50	132.60	202.40	280.80	354.40	395.60	434.40

^{1/}Generally, average earnings are figured over the period from 1950 until the worker reaches retirement age, becomes disabled, or dies. Up to 5 years of low earnings can be excluded. The maximum earnings creditable for social security are \$3,600 for 1951-1954; \$4,200 for 1955-1958; \$4,800 for 1959-1965; and \$6,600 for 1966-1967. The maximum creditable in 1968 and after is \$7,800, but average earnings cannot reach this amount until later. Because of this, the benefits shown in the last two columns on the right generally will not be payable until later. When a person is entitled to more than one benefit, the amount actually payable is limited to the larger of the benefits.

APPENDIX D

(a) Employee and Government premium rates of the Government-wide Federal employees health benefits plans

SERVICE BENEFIT PLAN

Type of Enrollment		1968		1969	
		Monthly Premium	Percent	Monthly Premium	Percent
Self only High Option	Employee pays	\$ 8.43	69.8	\$10.79	74.8
	Government pays	<u>3.64</u>	<u>30.2</u>	<u>3.64</u>	<u>25.2</u>
	Total cost	<u>12.07</u>	<u>100.0</u>	<u>14.43</u>	<u>100.0</u>
Self and Family High Option	Employee pays	20.58	69.9	26.35	74.8
	Government pays	<u>8.88</u>	<u>30.1</u>	<u>8.88</u>	<u>25.2</u>
	Total cost	<u>29.46</u>	<u>100.0</u>	<u>35.23</u>	<u>100.0</u>
Self only Low Option	Employee pays	3.64	50.0	3.81	51.1
	Government pays	<u>3.64</u>	<u>50.0</u>	<u>3.64</u>	<u>48.9</u>
	Total cost	<u>7.28</u>	<u>100.0</u>	<u>7.45</u>	<u>100.0</u>
Self and Family Low Option	Employee pays	8.88	50.0	9.19	50.9
	Government pays	<u>8.88</u>	<u>50.0</u>	<u>8.88</u>	<u>49.1</u>
	Total cost	<u>17.76</u>	<u>100.0</u>	<u>18.07</u>	<u>100.0</u>

INDEMNITY BENEFIT PLAN

Self Only High Option	Employee pays	8.06	68.9	11.57	76.1
	Government pays	<u>3.64</u>	<u>31.1</u>	<u>3.64</u>	<u>23.9</u>
	Total cost	<u>11.70</u>	<u>100.0</u>	<u>15.21</u>	<u>100.0</u>
Self and Family High Option	Employee pays	20.15	69.4	28.84	76.5
	Government pays	<u>8.88</u>	<u>30.6</u>	<u>8.88</u>	<u>23.5</u>
	Total cost	<u>29.03</u>	<u>100.0</u>	<u>37.72</u>	<u>100.0</u>
Self Only Low Option	Employee pays	3.16	50.0	4.57	55.7
	Government pays	<u>3.16</u>	<u>50.0</u>	<u>3.64</u>	<u>44.3</u>
	Total cost	<u>6.32</u>	<u>100.0</u>	<u>8.21</u>	<u>100.0</u>
Self and Family Low Option	Employee pays	7.58	50.0	10.82	54.9
	Government pays	<u>7.58</u>	<u>50.0</u>	<u>8.88</u>	<u>45.1</u>
	Total cost	<u>15.16</u>	<u>100.0</u>	<u>19.70</u>	<u>100.0</u>

(b) Benefit experience by patient category under high-option Federal employees health benefits plans authorized by the FEHB Act of 1959

Patient Category	Average benefits paid per covered person			
	11/1/62 - 10/31/63	11/1/63 - 10/31/64	11/1/64 - 12/31/65	1/1/66 - 12/31/66
A. Employees and dependents	\$ 57.45 (100.00%)	\$ 60.12 (100.00%)	\$ 65.29 (100.00%)	\$ 67.87 (100.00%)
Annuityants and dependents	131.14 (228.27%)	141.37 (235.15%)	149.67 (229.23%)	144.49 (212.89%)
B. Employees	68.24 (100.00%)	73.57 (100.00%)	80.88 (100.00%)	83.71 (100.00%)
Annuityants	175.83 (257.66%)	188.71 (256.50%)	199.23 (246.32%)	189.46 (226.33%)
C. Employee dependents	52.15 (100.00%)	53.90 (100.00%)	58.24 (100.00%)	60.78 (100.00%)
Annuityant dependents	85.35 (163.66%)	92.21 (171.08%)	98.30 (168.78%)	97.67 (160.69%)

1Average benefits paid for the 14-month period have been prorated for a 12-month period for purposes of comparison

Patient Category	Average number covered (in thousands)			
	11/1/62 - 10/31/63	11/1/63 - 10/31/64	11/1/64 - 12/31/65 (14 months)	1/1/66 - 12/31/66
A. Employees and dependents	4,922.4 (96.46%)	5,404.9 (95.51%)	5,548.9 (93.99%)	5,598.3 (92.23%)
annuityants and dependents	180.4 (3.54%)	254.2 (4.49%)	355.0 (6.01%)	471.9 (7.77%)
B. Employees	5,102.8 (100.00%)	5,659.1 (100.00%)	5,903.9 (100.00%)	6,070.2 (100.00%)
Annuityants	1,620.9 (94.67%)	1,711.0 (92.96%)	1,725.9 (90.52%)	1,731.3 (87.79%)
C. Employee dependents	91.3 (5.33%)	129.5 (7.04%)	180.7 (9.48%)	240.7 (12.21%)
Annuityant dependents	1,712.2 (100.00%)	1,840.5 (100.00%)	1,906.6 (100.00%)	1,972.0 (100.00%)
	3,301.5 (97.37%)	3,693.9 (96.73%)	3,823.0 (95.64%)	3,867.0 (94.36%)
	89.1 (2.63%)	124.7 (3.27%)	174.3 (4.36%)	231.2 (5.64%)
	3,390.6 (100.00%)	3,818.6 (100.00%)	3,997.3 (100.00%)	4,098.2 (100.00%)

Source: Data from annual reports of the U. S. Civil Service Commission, Bureau of Retirement and Insurance.

APPENDIX E

Comparison of major benefits under the Government-wide service benefits plan (high option) of the Federal employees health benefits program and the health insurance for the aged program (as of 1/1/69)

	Federal employees health benefits program-- Government-wide service benefit plan (high option).	Health insurance for the aged program-- title XVIII of the Social Security Act.
Inpatient hospital benefits	Up to 365 days of care for each hospital confinement, including inpatient psychiatric hospital service. Hospital services includes virtually all those ordinarily furnished by a hospital to its inpatients. Services of special nurses are covered, subject to deductible and coinsurance provisions.	Up to 90 days in each benefit period with patient paying a deductible of \$44 for the 1st 60 days plus a coinsurance amount of \$11 a day for each day in excess of 60 during a benefit period; plus lifetime reserve of additional 60 days with patient paying \$22 a day coinsurance. Hospital services included virtually all those ordinarily furnished by a hospital to its inpatients; payment will not be made for private-duty nursing. Inpatient psychiatric hospital service will be included, but a lifetime limitation of 190 days will be imposed. <u>1/</u>
Outpatient benefits	Full coverage for emergency hospital care rendered within 72 hours after an accident or medical emergency; X-ray and laboratory services; and radiation therapy. Other outpatient services are also covered under supplemental benefits, subject to deductible and coinsurance provisions.	Outpatient hospital services covered under medical insurance plan; outpatient physical therapy services and other outpatient health services also covered under medical insurance plan, subject to deductible and coinsurance provisions.

	Federal employees health benefits program-- Government-wide service benefit plan (high option).	Health insurance for the aged program-- title XVIII of the Social Security Act.
Posthospital extended care	Convalescent care excluded.	Up to 100 days in a benefit period for con- tinued treatment in an extended care facility after transfer from a hospital where the patient stayed 3 or more days. The first 20 days of care are covered in full. In each of remaining 80 days patient pays \$5.50 coinsurance. ^{1/}
Home health services	No specific provision. However, services fur- nished outside a hospital by a professional reg- istered nurse, and, under special circum- stances, by a licensed practical nurse, and physical therapy rendered by a qualified pro- fessional physical therapist are covered, sub- ject to deductible and coinsurance provisions.	Hospital insurance plan: posthospital home health services for up to 100 visits in a year after discharge from a hospital or extended care facility, if services are fur- nished under an approved plan. Services of visiting nurses, physical therapists, and other health workers are covered. Medical insurance plan: up to 100 visits during a calendar year with no require- ment of prior hospitalization, subject to deductible and coinsurance provisions.
Physicians' and surgeons' services	Under basic benefits, provides service or in- demnity benefits for surgery, inpatient visits and certain other physicians' services according to a fee schedule. Covered physicians' services not paid for or covered under basic benefits pay- able under supplemental benefits, subject to deductible and coinsurance provisions.	Covered, subject to deductible and coin- surance provisions, except that full payment made to hospital inpatients for services of radiologists and pathologists.

	Federal employees health benefits program-- Government-wide service benefit plan (high option).	Health insurance for the aged program-- title XVIII of the Social Security Act.
Private duty nursing	Services of a professional registered nurse furnished in or outside a hospital are covered. Services of a licensed practical nurse furnished in a hospital, and, under special circumstances, outside a hospital are covered, subject to deductible and coinsurance provisions.	Excluded.
Prescription drugs	Covered in or outside a hospital. Prescription drugs outside a hospital are subject to deductible and coinsurance provisions.	Covered only when furnished in a hospital, extended care facility or by a physician in his office. When provided in the physician's office, coverage is limited to those drugs which cannot be self-administered and are incidental to the physician's service.
Payment for services outside the United States	Inpatient and outpatient hospital benefits are covered in full. Payments for physicians' services are made according to a fee schedule. Payments in excess of fee schedule covered under supplemental benefits, subject to deductible and coinsurance provisions.	Generally excluded with minor exception related to emergency occurring in the United States.

	Federal employees health benefits program-- Government-wide service benefit plan (high option).	Health insurance for the aged program-- title XVIII of the Social Security Act.
Deductible and coin- surance payments	Individual pays \$100 deductible and 20 percent coinsurance in each benefit period for covered services and supplies not covered under the basic hospital and medical-surgical part of the program.	<p>Hospital insurance plan: in each benefit period, individual pays \$44 for first 60 days of care in a hospital plus \$11 a day for the remaining 30 days of care; \$22 a day for each of the 60 hospital lifetime reserve days; and \$5.50 a day for 21st through 100th day of care in an extended care facility. ^{1/}</p> <p>Medical insurance plan: patient pays \$50 annual deductible, plus 20 percent coin- surance.</p>

^{1/}For benefit periods beginning prior to 1969, the inpatient hospital deductible was \$40; the coinsurance amount for each inpatient hospital day was \$10; each hospital lifetime reserve day was \$20; and each extended care facility day was \$5.

APPENDIX F

Selected material from earlier reports on social security and Federal employment

- (a) Report of the President's Cabinet Committee on Federal Staff Retirement Systems, March 7, 1966

A. 4. Relationship to Social Security

- (a) Transfer of credits
(b) Social security minimum

Recommendation

Employees subject to the civil service retirement or the Foreign Service retirement and disability systems should be assured of survivor, disability, and retirement protection which is at least at the level provided under social security. This basic level of protection should be established through a twofold provision:

- (a) Workers who have employment subject to either of these Federal staff retirement systems but die or become disabled before they are eligible for protection under their staff retirement system or leave the Federal service and do not have protection under the staff retirement system when they die, become disabled, or reach retirement age, should have their credits under the staff retirement system transferred to social security; and
- (b) Employees and their survivors who become eligible for benefits under either of these staff retirement systems should be guaranteed that the benefit amounts they receive under the staff retirement system (or, if they are also eligible for social security benefits, under the staff retirement system and social security together) will be at least at the level that would be payable if their Federal service had been covered under social security

*

*

*

- (c) Health insurance protection

Recommendation

Federal employees covered only by a staff retirement system should have health insurance protection after they reach age 65 on the same basis as other workers. This should be accomplished by covering under the health insurance provisions of social security all such present Federal employees who desire this coverage, and all persons who in the

future enter or reenter Federal employment that is covered only by a staff retirement system.

For employees and annuitants who become eligible for social security health insurance and who desire broader protection than they obtain under social security, the Federal Government should make available complementary health insurance designed to maintain protection at approximately the level afforded by the Government-wide high-option plans, with the cost being shared by the Government and the participants. Coverage under present plans authorized by the Federal Employees Health Benefits Act of 1959 should be terminated for future entrants who will, of course, qualify for social security health insurance protection.

- (b) Joint Report of the United States Civil Service Commission and the Social Security Administration on Social Security and Federal Employment, March 13, 1965.

Summary and Conclusion

In summary, it appears to us that the principal advantages and disadvantages of the various approaches are as follows:

Approach No. 1 (employees covered under social security and the civil service retirement system, with no adjustment in the provisions of that system). Avoiding adjustment in the civil service retirement system provisions would be in accord with the views of employee organizations but the additional cost of this approach would be very high for employees and the Government. This approach would go beyond the objective of filling gaps in protection and would result in large increases in the benefits of many career employees; in some instances, retirement benefit amounts would exceed the employee's pay.

Approach No. 2 (same as approach No. 1 except that present and future employees could individually elect whether to come under social security). This approach has been favored by some employee organizations. The additional cost for the Government would not be quite as high as under Approach No. 1 since some employees would not elect social security coverage. However, the additional Government cost would go toward providing high benefits for those employees who elected coverage--mainly the better-paid employees who could readily afford to pay the social security employee contributions. Individual voluntary coverage under social security has always been considered undesirable because it involves adverse selection, which increases social security costs at the expense of those covered on a compulsory basis, and because some of those who have greatest need for social security protection would not elect coverage. Because some employees would not elect coverage, the objective of filling gaps in protection would not be fully achieved.

Approach No. 3 (employees covered under social security and the civil service retirement system, with adjustments in the retirement-system

provisions to take account of social security coverage). A plan carrying out this approach would fill the gaps in protection and could be designed to accomplish this objective at substantially less cost than approaches No. 1 and No. 2. This approach more than others has the potential to assure that the combined benefits (and the combined contributions) of people who shift between work covered by social security and the civil service retirement system would be at a planned and systematic level. This approach would, however, require some increase in cost beyond that necessary to fill the gaps in protection. Past proposals which involved adjustments of provisions of the civil service retirement system to take account of social security coverage have been strongly opposed by organizations of Federal employees.

Approach No. 4 (same as approach No. 3 except that present employees could elect to come under the new combined coverage or to continue under present provisions of the civil service retirement system and not come under social security). The considerations applicable to approach No. 3 are also generally applicable to this approach. The option provided under approach No. 4 would meet objections of some present employees based on individual circumstances, but this approach has also been strongly opposed by organizations of Federal employees because of the changes which would be made in the provisions of the civil service retirement system for the long run.

Approach No. 5 (a transfer-of-credit plan broad enough to provide social security protection for workers with Federal employment who do not qualify for protection under the civil service retirement system). A transfer-of-credit approach would not be as effective as coverage-coordination plans in assuring a planned and systematic level of contributions and benefits for workers who shift between Federal employment and other work. However, approach No. 5 would achieve the objective of filling major gaps in the protection of workers with Federal employment without involving costs, such as would be involved in the coverage plans, for providing nonessential benefit increases. Since this approach would not change the provisions of the civil service retirement system relative to career employees who stay in the Federal service, it would avoid objections which have been raised by employee organizations against plans which would make such changes.

Approach No. 6 (transfer of credits to social security in cases where employees die, become disabled, or separate before completing 5 years of Federal service). This approach would leave major gaps in protection unfilled, and would be even less effective than approach No. 5 in assuring a planned and systematic level of contributions and benefits for workers who shift between Federal employment and other work. It would, however, involve less additional cost than other approaches.

*

*

*

On the basis of our exploration of the advantages and disadvantages of these six approaches, a transfer-of-credit plan which follows approach No. 5 appears to offer "a workable and sound solution" to the problem of filling gaps in the protection of workers who have Federal employment. It does not, on the other hand, have certain advantages that some coverage-coordination plans have. This approach would require no changes in the provisions of the civil service retirement system, other than provisions for financing the plan, and would avoid difficulties which so far have prevented legislative action in this area. Thus, by providing benefit protection under social security in all situations where, under present law, no benefits would be payable under the civil service retirement system, the plan would close major gaps in the protection of workers who have Federal employment and would, moreover, be a relatively inexpensive approach.

Under this transfer-of-credit plan, credit for the Federal employment of workers who die, become disabled, or leave work covered under the civil service retirement system with less than 5 years of work under that system would be transferred to social security. (In this type of situation, the separated employees have no disability or survivorship protection under the civil service system.) Also, the credits of workers who leave Federal employment with more than 5 years of work covered under the civil service retirement system, and who lose their benefit protection under that system, would be transferred to social security. Appropriate financial adjustments between the two systems would be made to take account of the transfers of credit.

The Advisory Council on Social Security recently completed its study of the social security program and reported its findings and recommendations. In respect to social security protection for Federal employees, the Council recommended a transfer-of-credit plan that is similar to the one described above.

We recognize that this approach has shortcomings. For example, approach No. 5 would provide social security survivor and disability protection for workers with less than 5 years of Federal service which would be better than the survivor and disability protection afforded many of the workers with more than 5 years of service under the civil service retirement system. To correct this situation would require changes in the survivor and disability protection now provided by the civil service retirement system, perhaps by adding to a transfer-of-credit plan a provision guaranteeing benefit amounts that would be no less than those that would be paid under social security. Also, a transfer-of-credit plan would have no effect in situations where workers qualify for benefits under both social security and the civil service retirement system in total amounts which may be considered high in relation to the worker's lifetime earnings and contributions.

(c) Report of the Advisory Council on Social Security, January 1, 1965

Social security credit should be provided for the Federal employment of workers whose Federal service was covered under the civil service retirement system but who are not protected under that system at the time they retire, become disabled, or die.

Unlike almost all private pension plans and a high proportion of State and local retirement systems, the Federal civil service retirement system is not supplementary to the social security program. Thus when a person leaves Federal employment, his years of previous Federal service do not count toward social security benefits. Moreover, protection under the civil service retirement system does not start until after 5 years of Federal employment. As a result, although the civil service retirement system provides good protection for people who stay in Federal employment, Federal workers who leave, or those who die or become disabled before having worked for the Government for 5 years, may have inadequate protection or none at all under either civil service retirement or social security.

A practicable and relatively inexpensive way of filling the most serious gaps that result from this situation is to provide for social security credit for the Federal employment of those workers who are not protected under the civil service system at the time they retire, become disabled, or die. As part of the financing arrangement, the civil service retirement system would withhold, from the returns of contributions that are made from the civil service retirement system to separating employees, amounts equal to the social security employee contributions which would have been payable if their Federal work had been covered under social security. These withholdings would be transferred to the social security fund and additional financial adjustments made between the two systems to take account of the transfers of credit.

The plan includes the following principal elements, all of which the Council considers essential to its effective operation:

1. Credit would be transferred to social security for the Federal service of individuals who die, become disabled, or separate from work covered under the civil service retirement system after less than 5 years of Federal service. (At present, the only provision made where a person with less than 5 years of service dies or terminates his employment is for a refund of employee contributions.)
2. Credit would be transferred to social security for the Federal service of people who separate after 5 or more years of Federal work and obtain refunds of their contributions to the civil service retirement system. (The civil service retirement system does not provide any protection for people who separate from the civil service and take refunds.)

3. Former civil service employees who have not taken refunds of their civil service contributions and who die or who become disabled before age 62 could have credit for their Federal service transferred to social security. (Former employees do not have disability or survivorship protection under the civil service retirement system after separation.)

This transfer-of-credit approach would forego certain advantages which would be achieved by a straight extension of social security coverage. For example, an extension of social security coverage would provide superior protection for workers who become disabled or die relatively early in their careers. However, the transfer-of-credit approach the Council is suggesting would be considerably less costly for the Federal Government than a straight extension of social security coverage. Equally important, whereas an extension of social security coverage would require substantial modification of the civil service retirement system to take account of social security benefits and contributions, no modifications would be required to carry out the Council's recommendation except for the financing of the transfer of credits.

APPENDIX G

Illustrative Monthly Benefits Payable Under a Transfer-of-Credit Plan

The following charts illustrate the effect of the transfer-of-credit plan in cases involving various combinations of work under social security and under CSR.

In all cases, it is assumed that the plan has been in operation over the entire work lifetime of the individual, and that he earns at least \$7800 each year (the maximum amount creditable under social security under present law). It is also assumed that individuals begin working at age 22, with the exception of case F in which a female worker begins employment at age 18.

In none of the cases would monthly benefits be payable under the CSR system; if such benefits were payable, the transfer-of-credit plan would not apply. In all cases the employee's contributions (including interest, if Federal service was less than 5 years) to the CSR system are refunded, either to the separated employee or the survivors of the deceased employee or former employee. Under the transfer-of-credit plan, the amount refunded would be reduced by an amount equal to the social security contributions the employee would have paid if his Federal employment had been covered under social security.

CASE A

Mr. A works for 1 year under SS, then works 4 years under CSR, when he becomes disabled or dies.

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 1 child
		Worker alone	Worker, wife and 1 child	
Present Law	CSR	0	0	0
	SS	0	0	0
Transfer-of-credit plan	CSR	0	0	0
	SS	\$218	\$432	\$327

CASE B

Mr. B works 12 years under CSR, separates, then works 12 years under SS, when he becomes disabled or dies.

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 2 children
		Worker alone	Worker, wife and 2 children	
Present Law	CSR	0	0	0
	SS	\$156	\$330	\$330
Transfer-of-credit plan	CSR	0	0	0
	SS	218	434	434

CASE C

Mrs. C works 12 years under CSR, separates to become a housewife, and later becomes disabled.

	System paying benefits	Monthly disability benefits	
		Disabled 0 to 5 years after separation	Disabled more than 5 years after separation
Present Law	CSR	0	0
	SS	0	0
Transfer-of-credit plan	CSR	0	0
	SS	\$218	0

CASE D

Mr. D works 2 years under SS, then 10 years under CSR, separates, then works 1 year under SS when he becomes disabled or dies.

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 1 child
		Worker alone	Worker, wife and 1 child	
Present Law	CSR	0	0	0
	SS	0	0	0
Transfer-of-credit plan	CSR	0	0	0
	SS	\$218	\$432	\$327

CASE E

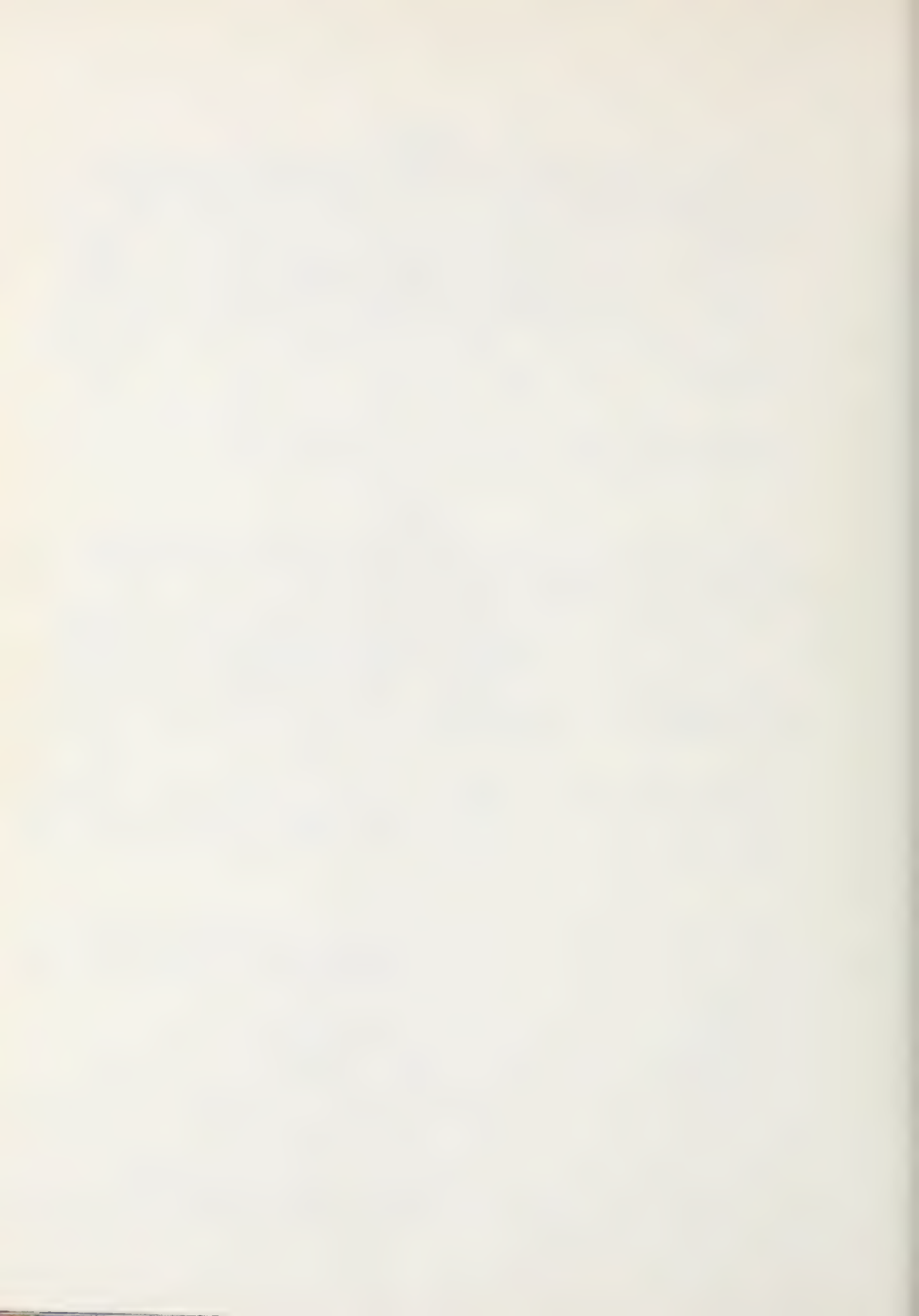
Mr. E works 24 years under CSR, separates, then works 12 years under SS, when he becomes disabled or dies.

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 1 child
		Worker alone	Worker, wife and 1 child	
Present Law	CSR	0	0	0
	SS	\$105	\$173	\$158
Transfer-of-credit plan	CSR	0	0	0
	SS	218	432	327

CASE F

Mrs. F works 4 years under CSR, separates. After 6 years at home, works 2 years under SS, when she becomes disabled or dies.

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, 2 children
		Worker alone	Worker and 2 children	
Present Law	CSR	0	0	0
	SS	0	0	\$242
Transfer-of-credit plan	CSR	0	0	0
	SS	\$128	\$434	327



APPENDIX H

Illustrative method for reducing social security benefit amounts of public employees who also receive substantial staff-retirement system benefits.

The reduction of social security benefits provided in this method would be applicable to governmental employees--Federal, State, and local--who receive substantial staff-retirement benefits in addition to heavily-weighted social security benefits. Because of basic differences between length-of-service, benefit-computation, and other provisions of the Federal civil service retirement system and of many of the State and local retirement systems, some differentials, designed to make the provisions universally effective for governmental employees, would have to be worked out. The key provision, however, would be to maintain, when social security benefits are generally increased in the future, the present minimum benefit of \$55 a month, and to provide close-to-minimum benefits increased only enough to blend them into the range of higher benefits, for civil service retirement annuitants if they are eligible for substantial staff-retirement system benefits. The special benefit levels could be maintained under successive general benefit increases until the Congress finds that an appropriate differential in the levels of benefits has been reached.

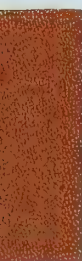
Social security benefits adjusted under this approach would gradually range upward from the present minimum benefit of \$55 rather than from a higher minimum enacted at the time of the next general social security benefit increase. The approach would affect only the lower, most heavily-weighted, benefit levels based on average monthly earnings of \$110 or less.

The following table indicates how the approach would affect social security retirement benefits paid to Federal civil service annuitants. Where benefits are also payable to a wife or dependent husband, the spouse's benefit would (as under present law) equal 50% of the worker's benefit. For illustrative purposes, the table columns headed "Generally Increased Benefits" and "Benefits for Certain Long-Term Civil Service Workers" are based on a 15% benefit increase and an increase in the minimum benefit to \$70 from the present \$55.

Average Monthly Earnings	Present Law Benefits	Generally Increased Benefits	Benefits for Certain Long-Term Civil Service Workers					
			YEARS OF GOVERNMENT SERVICE					
			30	31	32	33	34	35
\$ 74 or less	\$55.00	\$70.00	\$68.70	\$67.20	\$65.40	\$62.90	\$59.50	\$55.00
80	57.70	70.00	68.90	67.70	66.30	64.70	61.70	59.00
85	61.10	70.30	69.40	68.40	67.30	66.10	64.60	63.00
90	64.50	74.20	73.30	72.30	71.20	70.00	68.60	67.00
95	67.80	78.00	77.30	76.40	75.30	74.00	73.00	71.50
100	71.50	82.30	81.60	80.80	79.90	78.80	77.70	76.00
105	75.10	86.40	85.90	85.30	84.60	83.70	82.50	81.00
110	78.70	90.60	90.30	89.90	89.40	88.70	87.40	86.00
111	78.70	90.60	90.60	90.60	90.60	90.60	90.60	90.60

Under this method, adjustments would be made only in social security benefits based on average monthly earnings of \$110 or less because the most heavily-weighted benefits fall in this range. The \$55 minimum social security retirement benefit in present law equals at least 74% of a worker's average monthly earnings in covered work, and in some cases may be a much higher proportion. The present benefit based on average monthly earnings of \$110 (the main "bend point" in the social security benefit formula) is 71% of average monthly earnings. As the average monthly earnings increase above the \$110 bend point, the percentage declines more rapidly; at the highest level of average monthly earnings, the worker's benefit equals about one-third of his average monthly earnings covered by social security.





[COMMITTEE PRINT]

THE RETIREMENT TEST
UNDER
OLD-AGE AND SURVIVORS INSURANCE

A REPORT BY
THE DEPARTMENT OF HEALTH, EDUCATION,
AND WELFARE

A REPORT AND A SUPPLEMENTARY REPORT ON
A STUDY CALLED FOR BY THE COMMITTEE ON
WAYS AND MEANS OF THE HOUSE OF REPRESENTATIVES
IN HOUSE REPORT NO. 2288,
85TH CONGRESS, 2D SESSION

SUBMITTED TO THE
COMMITTEE ON WAYS AND MEANS
BY THE
DEPARTMENT OF HEALTH, EDUCATION,
AND WELFARE



Printed for the use of the Committee on Ways and Means

COMMITTEE ON WAYS AND MEANS

WILBUR D. MILLS, Arkansas, *Chairman*

AIME J. FORAND, Rhode Island	RICHARD M. SIMPSON, ¹ Pennsylvania
CECIL R. KING, California	NOAH M. MASON, Illinois
THOMAS J. O'BRIEN, Illinois	JOHN W. BYRNES, Wisconsin
HALE BOGGS, Louisiana	HOWARD H. BAKER, Tennessee
EUGENE J. KEOGH, New York	THOMAS B. CURTIS, Missouri
BURR P. HARRISON, Virginia	VICTOR A. KNOX, Michigan
FRANK M. KARSTEN, Missouri	JAMES B. UTT, California
A. S. HERLONG, Jr., Florida	JACKSON E. BETTS, Ohio
FRANK IKARD, Texas	BRUCE ALGER, Texas
THADDEUS M. MACHROWICZ, Michigan	ALBERT H. BOSCH, New York
JAMES B. FRAZIER, Jr., Tennessee	JOHN A. LAFORE, Jr., ² Pennsylvania
WILLIAM J. GREEN, Jr., Pennsylvania	
JOHN C. WATTS, Kentucky	
LEE METCALF, Montana	

LEO H. IRWIN, *Chief Counsel*

JOHN M. MARTIN, Jr., *Assistant Chief Counsel*

THOMAS A. MARTIN, *Minority Counsel*

GERARD M. BRANNON, *Professional Staff*

RAYMOND F. CONKLING, *Professional Staff*

¹ Died January 7, 1960.

² Appointed January 18, 1960.

LETTER OF TRANSMITTAL

MARCH 29, 1960.

Hon. WILBUR D. MILLS,
*Chairman, Committee on Ways and Means,
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: I have the honor to transmit to you a report on "The Retirement Test Under Old-Age and Survivors Insurance." This report was occasioned in part by the request of your committee in its report accompanying H.R. 13549, the Social Security Amendments of 1958 (85th Cong., 2d sess., H. Rept. 2288). You will recall that the report asked the Department to study certain aspects of the retirement test. This report presents the results of the Department's study.

Sincerely yours,

ARTHUR FLEMMING, *Secretary.*

III

CONTENTS

THE RETIREMENT TEST UNDER OLD-AGE AND SURVIVORS INSURANCE

	Page
Introduction.....	1
Why there is a test of retirement in old-age and survivors insurance.....	1
The provisions of the retirement test.....	2
How the retirement test developed.....	3
The number of people affected by the test.....	4
The committee's request.....	6
Possible elimination of the monthly measure of retirement.....	6
A separate retirement test for people with relatively high earnings.....	7
Conclusion.....	8
Summary of findings.....	8

ALTERNATIVE APPROACHES TO CHANGING THE RETIREMENT TEST UNDER OLD-AGE AND SURVIVORS INSURANCE

A supplementary report.....	11
-----------------------------	----

▼

THE RETIREMENT TEST UNDER OLD-AGE AND SURVIVORS INSURANCE

A Report on a Study Called for by the Committee on Ways and Means of the House of Representatives, 85th Congress, 2d Session, in House Report 2288 on H.R. 13549, the Social Security Amendments of 1958

The report of the Committee on Ways and Means of the House of Representatives on the Social Security Amendments of 1958 (H. Rept. 2288) contains the following section calling for a study of the retirement test under the old-age and survivors insurance program:

The committee has asked the Department of Health, Education, and Welfare to study certain aspects of the present test of retirement which seem to the committee to have questionable results. The present test is basically on an annual basis but under one of the provisions benefits are nevertheless paid for any month in which an individual earns \$80 or less (\$100 or less under the bill) and does not render substantial services in self-employment. Thus a person may have very high earnings in a single month and yet get benefits for the remaining 11 months in the year. We have asked the Department to consider possible changes in this provision.

In response to this request, the Department of Health, Education, and Welfare has studied various changes in the retirement test designed to meet the problem the committee has expressed interest in. This report sets forth the findings of that study.

WHY THERE IS A TEST OF RETIREMENT IN OLD-AGE AND SURVIVORS INSURANCE

The basic purpose of the old-age and survivors insurance program is to provide benefits for workers and their families when the worker's earnings can be presumed to have stopped or to have been substantially reduced as a result of his retirement, disability, or death. Since it is not reasonable to presume that all workers retire or suffer a significant reduction in earnings upon attainment of age 65, the program includes a "retirement test"—a provision intended to restrict the payment of benefits to those among the aged who can be presumed to have suffered such a loss.

If the retirement test had been removed from the program in June 1959, about 1.4 million people age 65 and over (working people and their dependents) who had not been getting benefits up until then could have immediately started to get benefits. Many of these people are working full time and earning as much as they ever have in their lives; the payment of full benefits to them would serve no socially useful purpose. And the removal of the test would not help the vast majority of beneficiaries now on the rolls who are unable to work or to get jobs.

2 RETIREMENT TEST UNDER OLD-AGE AND SURVIVORS INSURANCE

Payment of full benefits to all of the aged who are still working would be very costly, both in the immediate future and in the long run. Benefit costs in 1959 would have been increased by about \$2 billion if the retirement test had not been in effect for that year. In terms of long-range costs, the removal of the test would increase the level-premium cost of old-age and survivors insurance by 1 percent of taxable earnings—an increase of 12 percent in the estimated level-premium cost of the old-age and survivors insurance provisions (8.38 percent of taxable earnings).¹

The Social Security Board, the Federal Security Agency (predecessor of the Department of Health, Education, and Welfare), and the Department have always recommended in the past, and the Department recommends now, that a test of retirement be retained in the old-age and survivors insurance program.

THE PROVISIONS OF THE PRESENT RETIREMENT TEST²

Under the present retirement test a beneficiary gets all of his benefits when his earnings are \$1,200 or less in a year (this is the concept referred to in the report as the "exempt amount"). Anyone making \$1,200 or less is, in effect, presumed to be retired. Beneficiaries may get benefits, therefore, even though they have a significant amount of part-time work on a regular basis or have relatively high earnings for part of the year. (In fact, there undoubtedly are a few people at even this relatively low level of \$1,200 a year who are working full time and earning as much as they did before age 65.)

Ordinarily, a beneficiary has a check withheld³ for each \$80, or part of \$80, in excess of \$1,200 in earnings (the concept referred to throughout this report as the "unit of excess earnings" or the "excess unit"). This means that a beneficiary gets at least one benefit if his earnings are \$2,080 a year or less.⁴ The reason why the number of benefit payments that can be made in a year varies as earnings vary between \$1,200 and \$2,080 is to avoid a sharp line below which all benefits would be payable for a year and above which none would be payable. If the test were not graduated, it would not be uncommon to have the payment of \$2,000 or more in benefits depend on a few dollars of earnings. The law also provides that no matter what his annual earnings, a beneficiary gets a benefit for any month in which he neither earns wages of more than \$100 nor renders substantial services in self-employment (this provision is referred to as the "monthly measure of retirement").

The retirement test does not apply to beneficiaries aged 72 or over; after that age, benefits are payable regardless of the beneficiary's earnings. (This provision was enacted in recognition of the fact that a few people—particularly the self-employed—continue working to a very advanced age. Without this provision these people might never get any benefits even though they had paid contributions longer than most other beneficiaries.) The test applies to the earnings of beneficiaries in covered and noncovered work in the United States and

¹ The disability insurance part of the program is estimated to cost an additional 0.35 percent of taxable earnings.

² The limitation on the amount of earnings a beneficiary may have and get benefits, although designed primarily as a test of retirement for the aged worker, also applies to beneficiaries receiving dependents' and survivors' benefits under the program.

³ Where the dependents of a retired worker are getting benefits based on his earnings, those benefits are withheld for any month for which his benefit is withheld.

⁴ The figure \$2,080 is the result of adding to the \$1,200 exempt amount 11 times \$80. Thus at least 1 month's benefit is payable when earnings for a full year are \$1,200 plus \$880 (\$80 for each of the 11 months).

covered work outside the United States. (A special provision applies to beneficiaries working in noncovered work outside the United States so that levels of earnings in foreign countries need not be equated with those in the United States.)

HOW THE RETIREMENT TEST DEVELOPED

The reasons why the test has taken its present quite complicated form will be easier to understand if the considerations that led to the various changes that have been made in it through the years are reviewed.

From 1940 through 1950 the test of retirement applied only to earnings from covered employment. During those years work as an employee in commerce and industry was, generally speaking, the only employment covered by the program. The test was entirely on a monthly basis; the beneficiary got a benefit for any month in which he earned less than \$15 in covered employment.

Effective in 1951, when the self-employed were brought under the program, the test of retirement for the self-employed was put, for the most part, on an annual basis. (This was necessary because it is practically impossible in most cases for a self-employed person to compute his earnings on a monthly basis.) Specifically, it was provided that a person with self-employment earnings of \$600 or less for the year could get benefits for all months in the year no matter what his earnings were in any single month.

One part of the test, however, was placed on a monthly basis even though the earnings were figured over the whole year. No matter how high his annual earnings, a self-employed beneficiary could get a benefit for any month in which he did not render substantial services in his business. This latter provision served three purposes: First, it placed the self-employed beneficiary on a par with the wage earner in that he could receive a benefit for any month in which he did not work or in which he worked very little. Second, it allowed the payment of benefits to a self-employed beneficiary for months in which he did no work in the year in which he retired, even though his total earnings for the year were above the exempt amount by reason of work done before retirement. And third, the provision allowed payment of benefits to a person whose self-employment income came, not from work in operating the business, but rather from the investment he had in the business.

Two important criticisms of the test soon developed. First, there was criticism on the basis that the self-employed person could work, say, for 3 months, earn up to the annual exempt amount, and still get benefits for the whole year, while the wage earner who worked in 3 months and had the same total yearly earnings had 3 months' benefits withheld. (The 1950 amendments provided that a person could not get a benefit for any month in which he earned over \$50 in covered wages.) Second, a beneficiary who had both self-employment income and wages was in an unwarrantedly favorable position because he could meet the two tests separately; that is, he could have earnings from self-employment for the year of as much as the annual exempt amount, and also have wages in every month amounting to as much as the monthly exempt amount, and still get all of his benefits. The 1954 amendments removed these two anomalies by providing that earnings from self-employment and wage employ-

4 RETIREMENT TEST UNDER OLD-AGE AND SURVIVORS INSURANCE

ment would be combined for retirement test purposes and by providing a test with an annual exempt amount (\$1,200) for both the self-employed beneficiary and the wage-earner beneficiary.

The 1954 amendments also provided that the wage earner could get a benefit for any month in which he earned not more than \$80 (this amount was changed to \$100 beginning with 1959) regardless of his earnings for the year. This provision was included partly to avoid situations where a worker would not be able to get benefits under the 1954 amendments although he could have gotten them before. The provision also solved the problem of finding a way to pay benefits for the rest of a year when a worker retired in the middle of the year after his earnings were over the exempt amount. (Without the provision, a worker who retired in July, for example, after earning \$2,500 in that year could not get benefits for any part of the year.)

THE NUMBER OF PEOPLE AFFECTED BY THE TEST

At the end of June 1959, 11.1 million of the more than 15.5 million people age 65 and over in the United States were either getting old-age and survivors insurance benefits or could have gotten them if the breadwinner of the family had not been working. Of the 11.1 million, 4.9 million—44 percent—were age 72 or over and thus did not come under the operation of the retirement test. Of the remaining 6.2 million, an estimated 3.2 million did not have any earnings at all. Generally the retirement test does not affect the benefits these people get because most of them cannot work or cannot find work.⁵ Another 1 million are expected to earn less than \$900 in the year and also generally would not be affected by the test.⁶ We have, then, a total of 9.1 million—about four-fifths—of the 11.1 million eligible for benefits who in all likelihood are not directly or concretely affected by the retirement test.

There are, then, about 2 million of the aged who are directly affected by the retirement test. The 2 million fall into 3 groups. One group, numbering about 300,000, is the group of people who are getting full benefits and who are earning just under \$1,200 a year (between \$900 and \$1,200). A sizable proportion of these can be assumed to be deliberately holding their earnings to \$1,200 or just under that amount in order to get full benefits. For these people the test is clearly operating as a deterrent to work. The second group, also numbering about 300,000, is the group of people who are earning between \$1,200 and \$2,080 and under the present retirement test are getting some benefits for the year, the number of benefits being determined by the specific provisions of the retirement test.⁷ The third group, numbering about 1.4 million, is composed of people who are making over \$2,080 in a year and therefore are generally not getting benefits. Some of these people are working full time and earning about as they did before they attained age 65; others may have suffered significant reductions in earning power, although not enough to reduce their income below \$2,080. In general, the existence of the retirement test in its present form prevents these people from getting any benefits for the year.

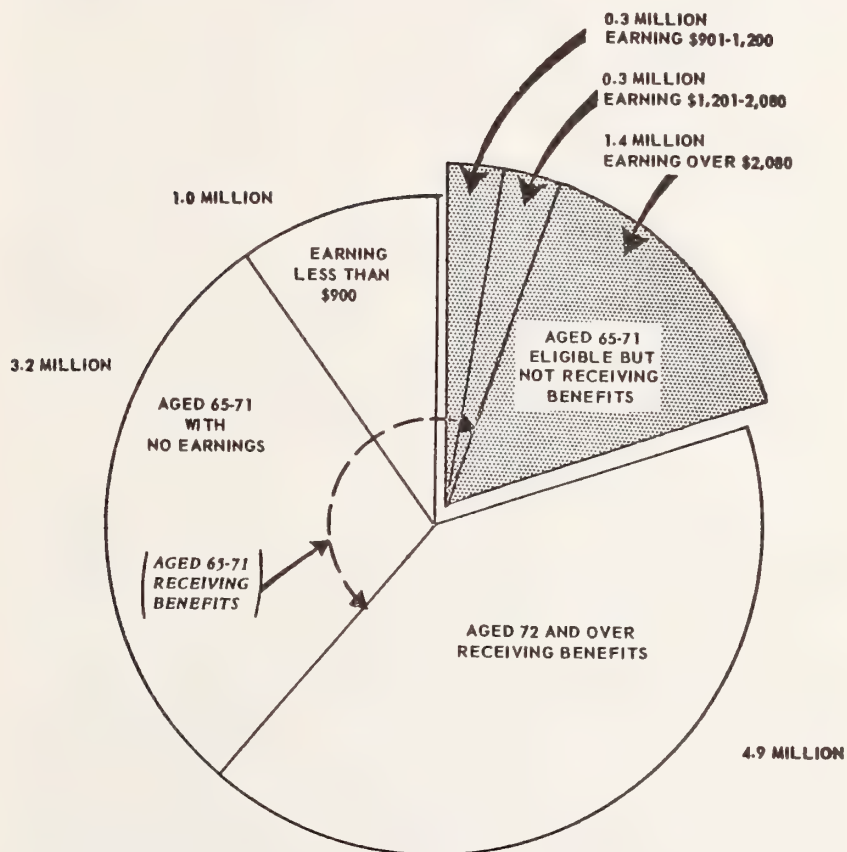
⁵ In the last survey of beneficiaries conducted by the Bureau of Old-Age and Survivors Insurance, about 70 percent of those not working said that they were not able to work.

⁶ This group may include a few who are deterred by the provisions of the test from earning more than they do.

⁷ These estimates exclude those who came on the rolls during the year and earned amounts falling in the indicated range, in most instances before "retirement."

THE EFFECT OF THE RETIREMENT TEST

2 MILLION ARE AFFECTED BY THE TEST



11.1 MILLION ELIGIBLE

JUNE 1959

THE COMMITTEE'S REQUEST

The committee asked the Department to consider possible changes in the provision of law under which a person may have very high earnings in a single month and yet get benefits for the remaining 11 months of the year. The situation the committee is concerned about grows out of the provision in the law setting up a monthly measure of retirement. This is the provision under which benefits are not withheld for any month in which the beneficiary neither earns wages of more than \$100 nor renders substantial services in self-employment, regardless of what his total earnings are within the year.

Possible elimination of the monthly measure of retirement

In seeking a solution for the problem raised by the committee the Department considered first whether the monthly measure of retirement should be eliminated, but came to the conclusion that it should not.

A major function of the monthly measure is to make it possible to pay benefits to a retired worker beginning with the first month of his retirement. Without a monthly measure of retirement, if a person retired from full-time work at the end of June, for example, after earning more than \$2,080 in a year, he could not get benefits until the following January. It would not seem reasonable for the program to require that a beneficiary go through the first several months of retirement without getting benefits. The benefits should start as soon as possible after earnings cease, when the need for the benefits arises; the monthly measure of retirement is the provision in the present law that makes this possible.

Moreover, since people move in and out of employment after reaching retirement age, the problem is not confined to the year of initial retirement for each beneficiary. For example, take a person who has been on the benefit rolls for a year, getting \$100 a month, and now has a chance to take a job in January, and does so. He thinks he will be able to keep on working and he spends most or all of this earnings for current living expenses. In June of the following year his employer goes out of business and he is unable to get another job. Now, because in the first months of the year he has earned, say, \$2,100, he cannot get benefits for the next 6 months, and will not have earnings either.

And the problem exists not only for people who leave employment in the middle of a year, but also for those who return to work during the course of a year. Take for example a beneficiary who has been retired from a regular full-time job and has gotten benefits of \$110 a month for a year or so. He is not satisfied to be idle and would like to work. An opportunity comes up for him in July of his second retirement year to take a full-time job paying \$85 a week. If he takes it he will earn \$2,210 and, therefore, will have to return the \$660 in benefits that he has already gotten or have his benefits withheld at a point when he is no longer earning. This will seem quite unfair to him, since he was not working during the months when he got the benefits. Moreover, the need to repay the benefits will be a significant barrier to his taking the job.

Removing the monthly measure of retirement would prevent the payment of benefits in cases where under present law some benefits are paid to the beneficiary in a year even though he may have had

high earnings for a few months of the year. But removal of the monthly measure would make it impossible to pay benefits promptly upon retirement, and therefore would prevent the program from carrying out a major one of its objectives. Accordingly, the Department recommends that a monthly measure of retirement be retained in the program.

A separate retirement test for people with relatively high earnings

The Department believes there is only one feasible proposal for preventing benefit payments where a person has relatively high earnings in a few months of the year. The Department is of the opinion, however, that the way in which the law operates at present is to be preferred, and it does not recommend adoption of this proposal. The proposal would add, on top of the present retirement test, a provision that no matter how little he worked, a person could not get full benefits if his earnings for the year were above some fairly high figure—for example, \$4,800 (the present maximum on taxable and creditable earnings). One form such a proposal might take would be to withhold one monthly benefit for, say, every \$400 of earnings above \$4,800 in a year. To take account of the peculiar circumstances of self-employed people, it might be provided that the proposal would not apply to a self-employed person unless he actually had done some work during the year.

Here are some examples illustrating how the proposal would operate:

1. A farmer moves into town after turning the operation of his farm over to a paid manager. He gets a profit of \$6,000 from the operation of the farm. If he did absolutely no work in connection with operating the farm he would get benefits for the full year, just as he does under present law. If, however, he helped with the work during the spring planting, he could get benefits for only 9 months; three benefits would be withheld because of his income from the farm even though he worked in only 1 month.

2. A movie star works on a picture during 2 months of a year and earns \$10,000. He does not work in the other months of the year. Under present law he could get benefits for the 10 months in which he did not work. Under the proposal he would get no benefits.

3. An operator of a mail-order business turns the management of the business over to his son and moves to Florida; his business yields him \$7,200 in earnings. Like the farmer in the first example, if he did not work at all he would get benefits for the whole year. If he did do any work at all in connection with the business he would get benefits for only 6 months; six benefits would be withheld.

As the examples show, a self-employed beneficiary with a business that produces a high income would, under the proposal, have to completely disassociate himself from the operation of his business in order to get full benefits. Under the proposal as much as a whole year's benefits would depend on whether the beneficiary did any work at all.

When a self-employed beneficiary has high earnings and yet works in his business very little during the year, most of his earnings probably come from his investment in the business rather than from the work he performed. Thus the effect of the proposal in many cases would

be to withhold benefits on the basis of investment income. But the wage earner beneficiary can get his benefits even though his invested savings yield a large income. There is no good reason why the self-employed person should not be able to have income from his investment in his business without losing his rights to benefits.⁸

More important than the undesirable effect just described is the fact that the proposal would add complexity to an already too complex provision in order to deny benefits to a very small group of beneficiaries. And the beneficiaries would be people who really are essentially retired. Generally speaking, any person who would be prevented from getting benefits solely by this provision is likely to be a person who has retired within the normal meaning of the word, and there is real justification for paying benefits to him for months in which he does not work. Because the proposal would deny benefits to only a very small group, it would not save any appreciable amount of money; there would be virtually no saving in the long run costs of the program.

Because of the serious disadvantages associated with it, the Department does not favor the adoption of this proposal nor of any proposal that would have a similar effect.

Conclusion.—The Department of Health, Education, and Welfare recommends that no action be taken to remove the monthly measure of retirement, or to put an additional earnings limitation on top of the present retirement test. Acceptance by the Congress of this recommendation would mean that the situation that the committee has expressed interest in—the payment of benefits to a person even though he may have had very high earnings for a few months in a year—will not be changed. The Department believes that, for the very few retired people who come out of retirement for a short time and earn substantial amounts of income, the most appropriate action is to suspend their benefits for the months in which they actually worked. This is the approach taken in the present law, and in fact the approach that has always been taken under the law. Ever since the program started paying monthly benefits the retirement test has been so framed that a person could get a benefit for any month in which he did not work, regardless of how much he worked or earned in any other month; and generally, over the years, this approach has been accepted without disfavor. Moreover, it is the only approach that is consistent with the treatment that should be, and is, accorded to a person in the year in which he first retires (that is, it is consistent with the payment of benefits to a person for months after retirement even if he has earned large sums in that same year before he retired).

SUMMARY OF FINDINGS

The findings and recommendations of the Department with respect to the retirement test under the old-age and survivors insurance program can be summarized as follows:

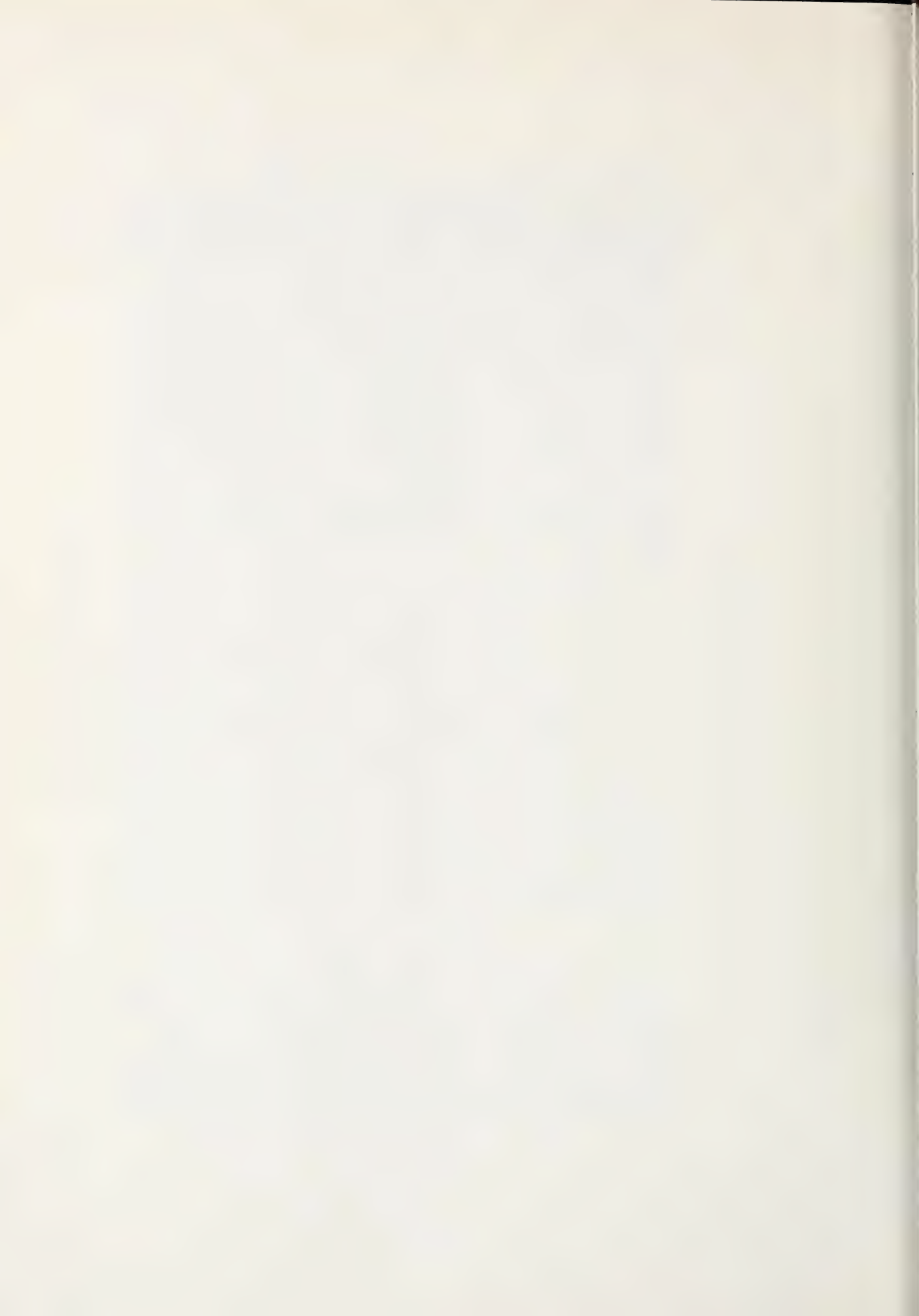
I. The retirement test in the old-age and survivors insurance program is necessary in order to assure that the funds of the program will be employed for socially useful purposes. Elimi-

⁸ Income from investments in real estate, stocks, bonds, and the like is not taxed for social security nor credited toward benefits, nor does it count for purposes of the retirement test. If benefits were withheld from people who have income from investments and other forms of savings the program would discourage personal savings.

nation of the retirement test would substantially increase the cost of the program, and the additional cost would be incurred chiefly as a result of paying full benefits to people who are fully employed at relatively high earnings. The Department therefore recommends that a test of retirement be retained in the program.

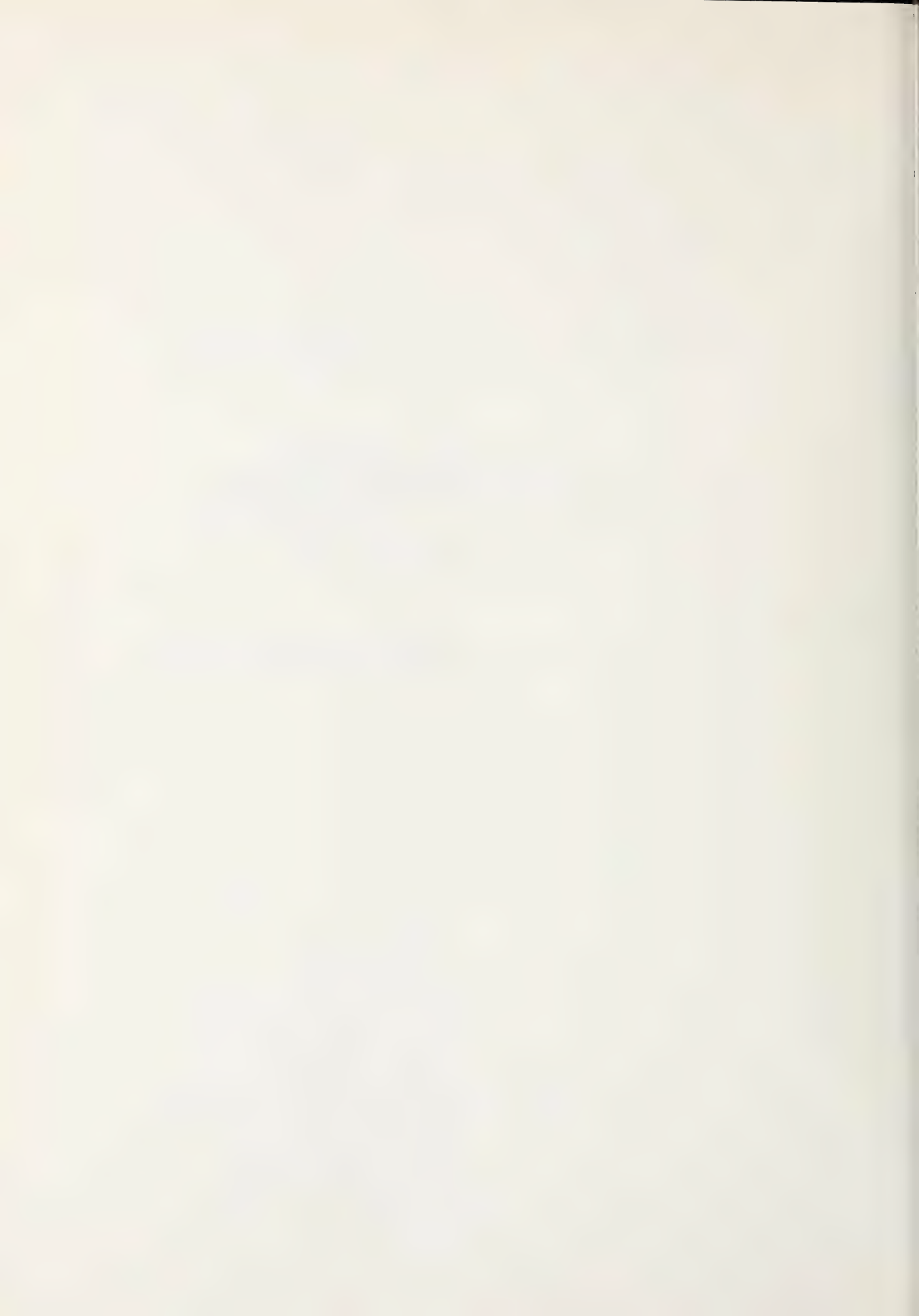
II. The Department recommends that the monthly measure of retirement be retained in the test, since to remove it would prevent the program from attaining its objective of making benefits available to people immediately upon retirement and during other periods when they do not have income from work.

III. The Department has developed, but does not recommend, a proposal that would eliminate the payment of benefits in the sort of case the committee asked the Department to study—the case of a person who is retired throughout most of the year but comes back into employment for a month or two and has high earnings. Under present law, because of the monthly test, he gets benefits for the months in which he did not work. The Department believes that it is desirable to withhold benefits only for the months in which the person works, as is done under present law.



ALTERNATIVE APPROACHES
TO CHANGING THE RETIREMENT TEST
UNDER OLD-AGE AND SURVIVORS INSURANCE

A SUPPLEMENTARY REPORT



LETTER OF TRANSMITTAL

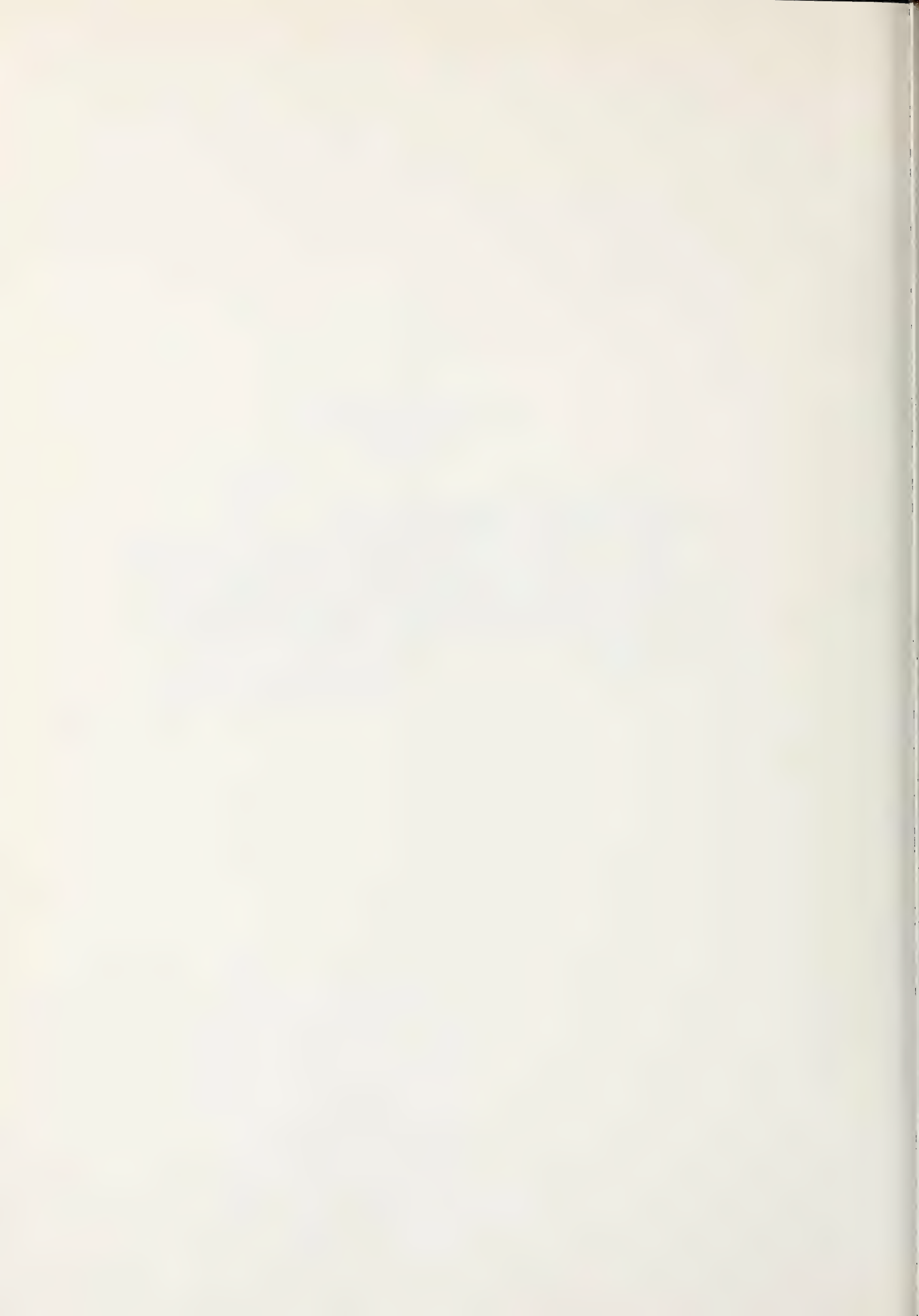
MARCH 31, 1960.

HON. WILBUR D. MILLS,
*Chairman, Committee on Ways and Means,
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: I am enclosing for the consideration of this committee a report entitled "Alternative Approaches to Changing the Retirement Test Under Old-Age and Survivors Insurance." This report is a supplement to the report on the Department's study of the retirement test, requested by the committee in its report on the 1958 amendments, that was transmitted to the committee a few days ago.

Sincerely,

ARTHUR FLEMMING, *Secretary.*



ALTERNATIVE APPROACHES TO CHANGING THE RETIREMENT TEST UNDER OLD-AGE AND SURVI- VORS INSURANCE

A Supplementary Report

The most telling criticism of the retirement test that can be made is that it discourages older people from working as much as they can and would like to, and therefore keeps them from contributing what they can to production and the economy and from bettering their own situations and leading more satisfying lives.

It is easy to exaggerate this effect of the retirement test. Powerful incentives to work for people age 65 and over now exist. Generally, earnings from work make possible a higher standard of living than most people can manage to obtain for themselves in retirement, since earnings generally are much higher than benefits. And there are many intangible satisfactions in work—meaningful activity, social relationships connected with work, and the feeling that the man has a contribution to make to the economy. Actually, most beneficiaries who are not working either are not well enough to work or cannot find jobs.

Nevertheless, it is unquestionably true that many older people would do more work than they do if the provisions of the retirement test did not operate so as to reduce the net addition to their income as a result of working. This is particularly true of people who are retired from their regular jobs and who would like to find some part-time or less demanding work to do. To the extent possible, retired people should be encouraged to accept jobs, earn money to improve their economic situations, and make a contribution to production and the national economy. Under present law it frequently happens that a beneficiary finds himself in a situation where, while he will be better off if he does a given amount of work than if he does no work at all, he would be still better off if he could have managed to restrict his work to a point where he would have earned somewhat less than he did. Thus the retirement test causes beneficiaries to restrict their earnings to lesser amounts than they could and would like to earn in order not to suffer a loss in total income.

An example or two may help to clarify the effect that the test has on incentives to work. Take the case of a beneficiary getting \$1,200 a year in benefits and faced with a choice between a job paying \$1,800 a year and one paying \$1,200. If he takes the \$1,800 job he will be only \$1,000 better off than if he does not do any work;¹ but if he takes the \$1,200 job his increase in income for the year will be \$1,200. Obviously, he would do better financially to take the \$1,200 job, although he might make more of a contribution to the economy, and feel better about his activities, if he could afford to, and did, take the \$1,800 job.

¹ The \$600 of earnings in excess of \$1,200 causes the withholding of eight benefits of \$100 each—\$860. Therefore, the worker has \$1,800 in earnings and \$400 in benefits, or a total of \$2,200 for the year—\$1,000 more than the \$1,200 in benefits he could have gotten if he had not worked at all.

Or take the case where a beneficiary has occasion to earn just over the \$1,200 exempt amount and lose a full month's benefit as a result. (Usually if he does earn just over \$1,200 it is through inadvertence or as a result of demands made upon him by his employer.) Whether the beneficiary actually does do the extra work and loses a month's benefit, or refrains from doing the extra work in order to get full benefits, the test is operating in an undesirable manner, since it either discourages him from work or penalizes him for working. And this situation can occur not only at the \$1,200 point, but at every one of the breaking points from \$1,200 to \$2,080.²

As a final example, take a man who with his wife has a benefit income of \$180 a month (the maximum under present law) and is offered a job paying \$3,000 a year. In this situation it is impossible for the family to lose in income as the result of the man's work; but the addition to his income if he takes the job and does \$3,000 worth of work will be only \$840.³ If he takes the job he will be somewhat better off financially than if he does not. And if he is chiefly interested in maximizing his income, or if the job is particularly interesting or not too demanding, he may take it in spite of its not being very profitable. On the other hand, he may well think that the extra \$840 in income does not make it worth his while to take the job. This is a situation in which it might be highly desirable, for the economy, the beneficiary, and the old-age and survivors insurance program, for the man to take the job and make whatever contribution he can. Yet the present law greatly reduces his incentive to do so.

It is generally agreed that provisions of law that operate to discourage people from working as much as they can and want to work are, in that respect, undesirable. Even when a person has attained an age that is generally regarded as the time when retirement from work is taken for granted, it is probably better for him to continue active, so far as his health will permit; both the individual himself and the economy as a whole will benefit by his continuing in productive activity.

It would be desirable, then, to bring the provisions of the law into harmony with the general system of incentives; that is, to devise a retirement test that would result in a person's having increased income as a result of increased work that he does.

On the other hand, a point that must be kept in mind in connection with any proposal that would eliminate or reduce the disincentive effect of the retirement test is that any such change that can be devised has the result of increasing the earnings level at which some benefits are payable. Generally speaking, at present no benefits can be paid to anyone who works throughout the year and makes more than \$2,080. All of the proposals described in the following discussion would increase the level of earnings up to which some benefits can be paid.

The fact must be faced that the retirement test is the center of an insoluble dilemma. There is, on the one hand, the need to conserve the funds of the program by not paying benefits to people who have substantial work income, and on the other hand, the need to avoid

² By "breaking point" is meant the point at which the beneficiary loses an additional month's benefit as a result of the operation of the \$80 unit of excess earnings; that is, if he earns more than \$1,280 he loses 2 months' benefits, if he earns more than \$1,360 he loses 3 months' benefits, and so on.

³ The beneficiary loses benefit income of \$2,160—12 months' benefits at \$180 a month. Since he would have had \$2,160 had he not worked and since he has \$3,000 as a result of working, the net addition to his income is \$840.

interfering with incentives to work. Both of these objectives cannot be fully accomplished. The best that can be done is to accommodate the two, so that while the funds of the system are in large part directed to the most socially useful purposes, at the same time interference with incentives to work is kept at a reasonably low level.

PROPOSALS TO IMPROVE INCENTIVES

An increase in the exempt amount

The proposal for changing the retirement test that is most frequently advanced is to increase the exempt amount above the present \$1,200 level—for example, to \$1,500. This proposal has a great deal of popular appeal. It is the kind of change in the retirement test that people usually think of first—in some cases, perhaps, because the \$1,200 exempt amount is the only part of the retirement test that they are familiar with. And an increase in the exempt amount would result in increased income for many beneficiaries. People who are able to control their earnings and who now limit them to \$1,200 in a year would be encouraged to increase their work to the point where they earned \$1,500 (if that were the new exempt amount), and all those who earn between \$1,200 and \$2,380⁴ would get more benefits than they can under present law.

Increasing the exempt amount would not, however, have much effect on the problem of improving incentives to work, except for amounts of earnings up to the new exempt amount, nor would it remove any of the problems and inequities of the present test; it would merely change the point at which they occur. If the new amount were \$1,500, a man who had a choice between a job paying \$1,800 and a job paying \$1,500 would generally do better financially to take the lower paying job; and the person who planned to earn exactly \$1,500 and inadvertently went just over that amount would have the same problem of losing more in benefits than his earnings above the exempt amount.

If the exempt amount were raised an increase in the other elements of the test—the unit of excess earnings (now \$80) and the monthly measure of retirement (now \$100)—might seem to be called for. Setting the excess unit and the monthly measure at the same amount, and both at one-twelfth of the exempt amount, has the merit of simplicity, but it is not essential that all three elements correspond. It is quite important for the sake of public understanding that the monthly measure of retirement be one-twelfth of the exempt amount. People interpret \$1,200 a year to mean \$100 a month. Before the 1958 amendments, when the exempt amount was \$1,200 and the monthly measure \$80, many people did not understand that they could not get benefits for a month in which they made over \$80 but less than \$100, and many incurred losses on that account. If in addition to an increase in the exempt amount to \$1,500 the monthly measure of retirement were increased to \$125, the increase in the cost of the program would be 0.11 percent of payroll. If the exempt amount were increased to \$1,800 and the monthly measure were set at \$150, the increase in the cost of the program would be 0.24 percent of payroll.

⁴ The \$2,380 figure is \$1,500 plus \$880 (i.e., 11 times \$80).

An increase in the unit of excess earnings

Another way of reducing the effect of the retirement test as a deterrent to work at certain levels would be to increase the unit of excess earnings—the amount (now \$80) by which earnings in excess of \$1,200 are divided to determine the number of benefits that must be withheld because of earnings. Since a month's benefit is withheld for every \$80 in excess earnings, anyone whose benefits amount to less than \$80 has some incentive to work and earn more than \$1,200 now, since in general he loses less in benefits than the amount of his excess earnings. Increasing the \$80 unit would provide a positive incentive to earn above \$1,200 for all those whose benefit amounts were less than the amount of the new excess unit, and for all other beneficiaries it would in general reduce the loss in total income because of earnings in excess of \$1,200.

In order to eliminate reductions in income as a result of work for the great majority of the beneficiaries, a substantial increase in the unit of excess earnings would be necessary. An increase to \$125 would mean that a million retired worker beneficiary families—15 percent of all such families—would still be losing more in benefits than the unit of excess earnings that caused the loss. Actually an increase to \$175 or \$200 would be necessary to approach a complete solution to the problem. With an excess unit of \$175 all but six-tenths of 1 percent of the retired worker beneficiary families would have benefits lower than the excess unit and hence would stand to lose less in benefits than the amount of their excess earnings. At \$200 the figure would be four-tenths of 1 percent.

Generally, the families that would still be at a disadvantage with a \$175 or \$200 excess unit would be those consisting of a retired worker, wife and child, or a retired worker with two or more children, getting benefits at the higher amounts. Families of this composition are, of course, rare.

An example may be helpful to show how the proposal would work. Take the case of a beneficiary with a benefit of \$100 a month and suppose he were to earn \$1,760 in a year. Under present law, 7 months' benefits (\$700) would be withheld for his \$560 of excess earnings, so that in comparison with the situation in which he could earn exactly \$1,200, he would lose \$140 (\$700 minus \$560 of excess earnings) in total income for the year. He therefore would not earn \$1,760 if he understood the law and had any control over how much he could work and earn. Under a proposal to increase the unit of excess earnings to, say, \$175, this same beneficiary, because of his \$560 in excess earnings, would have 4 months' benefits (\$400) withheld. He would thus have gained \$160 in total income from his earnings of \$560 above \$1,200.

A peculiarity of this proposal may be brought out by changing the benefit amount in the foregoing example. Suppose a man's benefit were \$80 a month instead of \$100. The beneficiary would still have 4 months' benefits withheld, but the amount withheld would be only \$320 instead of \$400. Thus the second beneficiary would have gained \$240 rather than \$160 as a result of the same amount of work. The effect of this proposal on incentives to work, then, is quite capricious; the net addition to the beneficiary's income as a result of work is not related at all to the amount earned by doing the work.

An increase in the excess unit, moreover, does not completely solve the problem of benefit losses as a result of earnings, even for the beneficiary whose family benefit amount is smaller than the excess unit. In any situation where a beneficiary makes just over the exempt amount, or just over that amount plus one or more excess units, and consequently loses a month's benefit as a result of having excess earnings amounting to a fractional part of the unit, he can lose in total income. Thus if a beneficiary made the mistake of making \$1,201 in a year, no matter what the amount of the excess unit, he would lose a whole month's benefit for the extra dollar in earnings.

Still another example may be helpful at this point. Assume that the excess unit were increased to \$175. A beneficiary who has benefits amounting to \$100 a month has an opportunity to take a job at \$1,900 a year. If he does, he will lose 4 months' benefits—one for each \$175 in excess of \$1,200. He expects, then, that his total income will be \$1,900 in earnings and \$800 in benefits, for a total of \$2,700. His employer is caught with a rush job and asks him to do extra work. He does so, and is paid \$25 extra for the work. For the \$25 additional earnings he loses a whole month's benefit of \$100, so that he is actually \$75 worse off as a result of doing the extra work.

It is clear, then, that an increase in the unit of excess earnings could not of itself solve the problem of benefit losses as a result of work even if the unit were increased as high as \$175 or \$200.

An increase in the excess unit would, of course, increase the long-range cost of the program, the amount of the increase depending upon the size of the increase in the unit. An increase in the unit to \$175 would cost 0.15 percent; to \$200, 0.19 percent.

Various proposals for reducing benefits in proportion to the amount of earnings

The Department has also considered proposals to reduce benefit payments in some ratio to the amount of the beneficiary's earnings in excess of \$1,200. The results of the Department's analysis are set forth below.

1. *A dollar-for-dollar adjustment plan.*—As one way of reducing the effect of the retirement test in deterring beneficiaries from working it has been suggested that instead of withholding a whole benefit amount for each \$80 of excess earnings, as is done under present law, benefits should be reduced by the amount of excess earnings. Obviously, under such a proposal (except for the expenses that arise out of his work, such as taxes and carfare) the beneficiary would never have less in total income as a result of working.

A change of this sort would undoubtedly make the retirement test easier to understand and more acceptable than it is now. The \$80 excess unit is a completely arbitrary element in the retirement test, included to avoid the sharp borderline that would occur if there were not some graded reduction of benefits to take account of earnings over the exempt amount. (It would be unreasonable to withhold a year's benefits for a dollar of excess earnings, and the \$80 provision was included in the law to prevent that result.) Since the amount of \$80 is arbitrary it is difficult for beneficiaries to understand.

On the other hand, a dollar-for-dollar-reduction provision really does very little to improve incentives for the aged to work. To tell a person that while he will be no worse off (except for the expenses

connected with work) as a result of working, he will be no better off either, does not constitute providing an incentive for him to work. All the proposal really does in this area is to reduce the disincentive that operates under present law.

A dollar-for-dollar reduction provision, by itself, would increase program costs by 0.04 percent of payroll. It is quite unlikely, though, that a dollar-for-dollar provision unaccompanied by any other change would be acceptable, because it would mean that a significant number of beneficiaries would be worse off than they are under the present law. They would be those beneficiaries who get less than \$80 in benefits and earn in excess of \$1,200 a year. Under present law, as a result of the \$80 excess unit, a beneficiary getting benefits of, say, \$60 loses only that \$60 for every \$80 of excess earnings, whereas under the proposal he would lose \$80. The only way to reduce this deliberalization to an acceptable amount with a dollar-for-dollar reduction and at the same time avoid adding complexity to the law would be to accompany the proposal with a substantial increase in the exempt amount—perhaps to as much as \$1,800. This would mean a very substantial increase in cost—as much as 0.4 percent of payroll.⁵

2. *A proposal to withhold \$1 in benefits for each \$2 of excess earnings.*—A way to avoid the significant deliberalization that would arise in connection with a dollar-for-dollar-reduction provision, and at the same time to go farther in the direction of improving incentives for older people to work, would be to withhold \$1 in benefits for each \$2 of excess earnings. Obviously, if this were done, the beneficiary who worked would always be better off financially as a result of working. And there would be a deliberalization from present law only for beneficiaries with benefits amounting to less than \$40 who nevertheless are able to earn more than \$1,200. Cases in which people getting benefits as low as \$40 would earn significantly above \$1,200 a year would be rare, so that as a practical matter the deliberalization would not be significant.

Under this proposal there would no longer be any reason for beneficiaries to seek out jobs at \$1,200 or less or to otherwise limit their work activity. The effect of the proposal would be to support rather than interfere with the desire of older people to continue to work to the extent that they are able to do so. The proposal would furnish a significant incentive to work throughout the entire range of benefits and would avoid the anomalies that arise at the various breaking points in the present test.

The proposal would result in the payment of some benefits to people earning at relatively high levels. A man and wife getting the present maximum benefits of \$180, for example, would get \$100

⁵ Another way to avoid deliberalization with a dollar-for-dollar-reduction provision would be to add such a provision on top of the present law—as an addition to the present retirement test rather than as a substitute for part of it. But to do that would be to make the retirement test almost impossibly complicated. Moreover, it would not actually guarantee the beneficiary against loss as a result of doing some additional amount of work over what he might have done. The anomaly of losing in total income as a result of additional earnings would continue to occur at breaking points throughout the range affected by the test for all those beneficiaries getting less than \$80 a month.

in benefits for a year if the man's earnings amounted to \$5,320. The cost of the proposal would be 0.11 percent of payroll.⁶

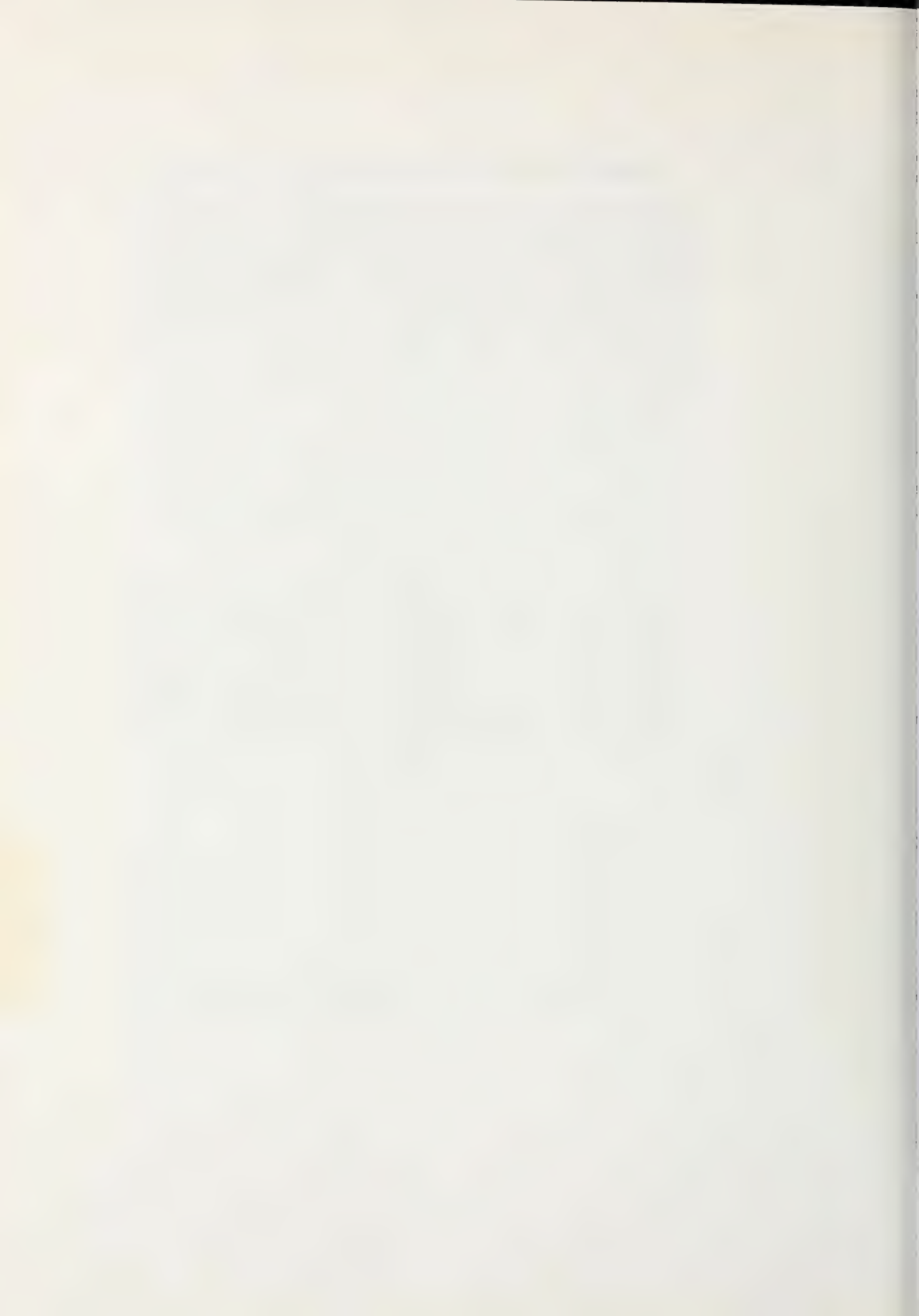
3. *A combination proposal: Withhold \$1 in benefits for each \$2 of earnings in excess of \$1,200 and up to \$2,400, and withhold \$1 in benefits for each \$1 in earnings in excess of \$2,400.*—The chief disadvantages of the 1-for-2 proposal are the increases in cost and the fact that some benefits would be paid to people at relatively high earnings levels. A way to reduce these disadvantages would be to modify the proposal by a provision that earnings above \$2,400 a year would reduce benefits dollar for dollar. With this modification the man and wife getting the present maximum of \$180 would get no benefits for the year at the point when the man's earnings reached \$3,960, and the cost would be 0.08 percent of payroll rather than 0.11 percent. The proposal would furnish an incentive to work at all ranges of benefits, and for all earnings levels up to \$2,400, and would guarantee against loss as a result of earning above that amount. And while it does not have the simplicity that is so attractive about the straight 1-for-2 proposal, it nevertheless, like the straight 1-for-2 proposal, would remove the incentive for the beneficiary to seek out jobs paying less than \$1,200 and to restrict his work activity so as not to go above that amount.

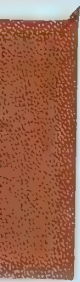
CONCLUSION

Analysis of these various proposals for changing the retirement test shows that there are advantages and disadvantages to all. Any of the proposals considered would involve significant additional cost to the system and would require additional financing.

⁶ Other ratios than 1 for 2 are possible, of course. Consideration was given, for example, to a 1-for-4 plan; that is, a plan for reducing benefits by 75 cents for each dollar of earnings. A 1-for-4 plan would of course be cheaper than a 1-for-2 plan, and would mean that the earnings level at which no benefits would be payable for the year would be lower. But a 1-for-4 plan would mean a deliberalization for all beneficiaries with benefit amounts of \$60 or less—a significant group; and the incentive effect of permitting a person to keep 25 cents out of each dollar of earnings (out of which 25 cents he must pay taxes and the expenses that arise in connection with his work) is not very great, though considerably greater, of course, than that of the present law.







THE RETIREMENT TEST UNDER SOCIAL SECURITY

LETTER

FROM

THE SECRETARY OF HEALTH, EDUCATION,
AND WELFARE

TRANSMITTING

A REPORT RESULTING FROM A STUDY OF THE RETIRE-
MENT TEST PURSUANT TO PUBLIC LAW 90-248, THE
SOCIAL SECURITY AMENDMENTS OF 1967



JANUARY 9, 1969.—Referred to the Committee on Ways and Means,
and ordered to be printed, with illustrations

U.S. GOVERNMENT PRINTING OFFICE

23-205

WASHINGTON : 1969



LETTERS OF TRANSMITTAL

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., January 7, 1969.

HON. JOHN W. McCORMACK,
Speaker of the House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: I have the honor to transmit to you a report on "The Retirement Test Under Social Security." The report resulted from a study of the retirement test called for by the Congress in Public Law 90-248, the Social Security Amendments of 1967. The report presents the results of the Department's study.

Over the years there have been considerable confusion and misunderstanding of the retirement test in social security. Many people feel that it should be eliminated from the program, arguing that the beneficiaries have paid for their benefits and should get them as soon as they are otherwise eligible without regard to whether they have retired. This of course is erroneous. What the people have been paying for is a retirement benefit prior to age 72 and an annuity payable automatically at age 72 regardless of whether they are working, not an annuity payable from age 65 on. The idea, then, that people otherwise eligible for social security benefits should get such benefits regardless of the amount of their earnings because they have paid for their benefits is not a soundly based idea. Incidentally, taking the whole group of beneficiaries now on the rolls, they and the employers who have paid contributions on the earnings on which their benefits are based, together, have paid contributions that on the average cover only about 10 percent of the value of the benefits payable on those earnings.

Another misunderstanding that many people have is that a person who works after age 65 is treated unfairly as compared to a person who after retirement has income from savings and investments. People who think this way misunderstand the whole purpose of a retirement system, which is to pay benefits to partially replace lost earnings. If benefits were withheld because the person had income from savings, investments, a private pension plan or the like, the program would discourage people from saving in their productive years to have a more comfortable life in retirement than social security benefits alone can make possible. In fact the partnership that now exists between private pension plans and the social security program would be disrupted if nonwork income were to cause withholding of social security benefits. The 90,000 private pension plans now in effect in the United States have been designed to supplement the social security program, and the benefit levels under those plans take into account the fact that social security benefits will be payable upon retirement to those covered by the plans. If social security benefits were to be withheld because of the receipt of pensions under such plans, the advantages of

the combined Government-private effort in providing adequate retirement benefits would be seriously impaired.

Repeal of the retirement test would increase the cost of the social security program by \$2.5 billion a year now, and more in future years. In order to finance this additional cost it would be necessary to increase social security contributions for employers and employees by a total of 0.70 percent of taxable payroll or by 0.35 percent of taxable payroll each for employers and employees. Most of this additional cost would be incurred in order to pay benefits to people who are fully employed and earning as much as they ever did. I do not believe that this would be the best use of the income available to the social security program and therefore do not recommend repeal of the retirement test.

I am in favor, however, of certain changes in the retirement test. I recommend that the amount a social security beneficiary can earn in a year and still get all of his benefits—now \$1,680—be brought up to date with the increases in earnings levels that have occurred since the present exempt amount was enacted and kept up to date thereafter. This would require an increase in the annual exempt amount to \$1,800 with a corresponding increase from 140 to \$150 (one twelfth of the annual exempt amount) in the monthly exempt amount—the amount of wages which, regardless of his annual earnings, a beneficiary can earn in a given month and still receive his benefit for that month. In order to keep the annual exempt amount in line with changes in earnings levels in the future, I recommend that the law include a provision for automatically adjusting the exempt amount to rises in earnings levels.

In addition to these changes I recommend a change in the provision under which benefits are withheld when the beneficiary's earnings exceed the annual exempt amount. I recommend no change in the provision in present law under which \$1 in benefits is withheld for each \$2 of earnings for the first \$1,200 of earnings above the exempt amount. I do believe, however, that the provision under which \$1 in benefits is withheld for each \$1 of earnings above the \$1,200 \$1-for-\$2 reduction band should be changed so that \$3 in benefits is withheld for each \$4 of such earnings. With an \$1,800 exempt amount the \$3-for-\$4 reduction would apply to earnings above \$3,000.

These changes taken together would increase the cost of the social security program by an estimated 0.07 percent of taxable payroll, and, if effective January 1, 1970 (under existing benefit levels), would result in increased payments of \$285 million to beneficiaries in the first full year of operation.

I urge favorable consideration of these recommendations and their prompt enactment. Attached to the report is a draft of proposed legislation to carry out my recommendations.

Sincerely,

WILBUR J. COHEN, *Secretary*.

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., January 3, 1969.

THE PRESIDENT,
The White House,
Washington, D. C.

DEAR MR. PRESIDENT: I have the honor to transmit to you a report on "The Retirement Test under Social Security." The report resulted from a study of the retirement test called for by the Congress in Public Law 90-248, the Social Security Amendments of 1967. The report presents the results of the Department's study.

Over the years there have been considerable confusion and misunderstanding of the retirement test in social security. Many people feel that it should be eliminated from the program, arguing that the beneficiaries have paid for their benefits and should get them as soon as they are otherwise eligible without regard to whether they have retired. This of course is erroneous. What the people have been paying for is a retirement benefit prior to age 72 and an annuity payable automatically at age 72 regardless of whether they are working, not an annuity payable from age 65 on. The idea, then, that people otherwise eligible for social security benefits should get such benefits regardless of the amount of their earnings because they have paid for their benefits is not a soundly based idea. Incidentally, taking the whole group of beneficiaries now on the rolls, they and the employers who have paid contributions on the earnings on which their benefits are based, together, have paid contributions that on the average cover only about 10 percent of the value of the benefits payable on those earnings.

Another misunderstanding that many people have is that a person who works after age 65 is treated unfairly as compared to a person who after retirement has income from savings and investments. People who think this way misunderstand the whole purpose of a retirement system, which is to pay benefits to partially replace lost earnings. If benefits were withheld because the person had income from savings, investments, a private pension plan or the like, the program would discourage people from saving in their productive years to have a more comfortable life in retirement than social security benefits alone can make possible. In fact the partnership that now exists between private pension plans and the social security program would be disrupted if nonwork income were to cause withholding of social security benefits. The 90,000 private pension plans now in effect in the United States have been designed to supplement the social security program, and the benefit levels under those plans take into account the fact that social security benefits will be payable upon retirement to those covered by the plans. If social security benefits were to be withheld because of the receipt of pensions under such plans, the advantages of the combined Government-private effort in providing adequate retirement benefits would be seriously impaired.

Repeal of the retirement test would increase the cost of the social security program by \$2.5 billion a year now, and more in the future years. In order to finance this additional cost it would be necessary to increase social security contributions for employers and employees by a total of 0.70 percent of taxable payroll or by 0.35 percent of taxable payroll each for employers and employees. Most of this additional cost would be incurred in order to pay benefits to people who are fully

employed and earning as much as they ever did. I do not believe that this would be the best use of the income available to the social security program and therefore do not recommend repeal of the retirement test.

I am in favor, however, of certain changes in the retirement test. I recommend that the amount a social security beneficiary can earn in a year and still get all of his benefits—now \$1,680—be brought up to date with the increases in earnings levels that have occurred since the present exempt amount was enacted and kept up to date thereafter. This would require an increase in the annual exempt amount to \$1,800 with a corresponding increase from \$140 to \$150 (one-twelfth of the annual exempt amount) in the monthly exempt amount—the amount of wages which, regardless of his annual earnings, a beneficiary can earn in a given month and still receive his benefit for that month. In order to keep the annual exempt amount in line with changes in earnings levels in the future, I recommend that the law include a provision for automatically adjusting the exempt amount to rises in earnings levels.

In addition to these changes I recommend a change in the provision under which benefits are withheld when the beneficiary's earnings exceed the annual exempt amount. I recommend no change in the provision in present law under which \$1 in benefits is withheld for each \$2 of earnings for the first \$1,200 of earnings above the exempt amount. I do believe, however, that the provision under which \$1 in benefits is withheld for each \$1 of earnings above the \$1,200 \$1-for-\$2 reduction band should be changed so that \$3 in benefits is withheld for each \$4 of such earnings. With an \$1,800 exempt amount the \$3-for-\$4 reduction would apply to earnings above \$3,000.

These changes taken together would increase the cost of the social security program by an estimated 0.07 percent of taxable payroll, and, if effective January 1, 1970 (under existing benefit levels), would result in increased payments of \$285 million to beneficiaries in the first full year of operation.

I have urged favorable consideration of these recommendations and their prompt enactment. Attached to the report is a draft of proposed legislation to carry out my recommendations.

Faithfully yours,

WILBUR J. COHEN, *Secretary*.

THE RETIREMENT TEST

UNDER

SOCIAL SECURITY

A REPORT ON A STUDY CALLED FOR BY THE CONGRESS
IN P.L. 90-248, THE SOCIAL SECURITY AMENDMENTS OF
1967

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE



CONTENTS

	Page
I. Introduction.....	1
II. Background.....	1
Why the law contains a retirement test.....	1
The present retirement test.....	2
How many people are affected by the retirement test?.....	6
III. Analysis of various changes that could be made in the retirement test..	9
The monthly test.....	9
The annual exempt amount.....	13
Automatic adjustment of the exempt amount.....	15
Adjustment of benefits where earnings exceed the annual exempt amount.....	16
The age at which the test ceases to apply.....	19
A variable exempt amount.....	19
Special provisions for certain groups.....	21
IV. A delayed retirement credit.....	22
V. The foreign work test.....	23

CHARTS AND TABLES

Table 1.—Old-age, survivors, and disability insurance: Persons aged 65 and over and eligible for social security cash benefits on January 1, 1969, and number affected by the retirement test in 1968.....	7
Chart 1.—Number of people affected by retirement test.....	8
Table 2.—Annual benefits payable under present law and under a proposal to modify the monthly test.....	12
Chart 2.—Earnings levels of social security beneficiaries aged 63-72 and 73 and older in 1963.....	14
Table 3.—Comparison of median earnings of all male workers in covered employment with exempt amount of the retirement test in selected years..	16
Chart 3.—Total disposable income for a man age 65 getting a specified benefit under present law and under two proposals.....	17
Table 4.—Examples of monthly benefits payable to a man age 65 in 1968 under present law and under four proposals for a delayed retirement credit.....	23

APPENDIXES

A.—Cost of retirement test proposals.....	25
B.—Cost of delayed retirement credit proposals.....	26
C.—Draft of proposed legislation.....	27



THE RETIREMENT TEST UNDER THE SOCIAL SECURITY PROGRAM

**A REPORT ON A STUDY CALLED FOR BY THE 90TH
CONGRESS IN PUBLIC LAW 90-248, THE SOCIAL
SECURITY AMENDMENTS OF 1967**

I. INTRODUCTION

The directive of the Congress, which is included in Public Law 90-248, the Social Security Amendments of 1967, that the Department study the retirement test under social security reads:

(a) The Secretary of Health, Education, and Welfare is authorized and directed to study (1) the existing retirement test and proposals for the modification of such test (including proposals for an increase in old-age insurance benefit amounts on account of delayed retirement) * * *.

(b) On or before January 1, 1969, the Secretary shall transmit to the President and the Congress a report which shall contain his findings of fact and any conclusions or recommendations he may have.

A major report on this subject was submitted by the Department in 1960, at the request of the Committee on Ways and Means of the House of Representatives, and gave findings and recommendations on the test as it existed at that time. Generally speaking, the recommendations in that report have been followed and have been instrumental in shaping the test into its present form.

The present study focuses principally on two areas of congressional interest mentioned during consideration of the Social Security Amendments of 1967. The Committee on Ways and Means was particularly interested in the provision under which a person can have substantial earnings in part of the year and still get social security benefits for the remainder of the year. In its report on the 1967 amendments (House Report No. 544) the Committee stated:

While the overall effect of the present retirement test provides generally satisfactory results, it still permits a person to have substantial earnings in part of the year and to receive substantial social security benefits in the remainder of the year. In the course of its deliberations your committee asked the Social Security Administration to give further and more intensive study to this problem.

Senate interest centered on proposals to increase old-age insurance benefits for those workers who continue to work beyond age 65.

II. BACKGROUND

WHY THE LAW CONTAINS A RETIREMENT TEST

In a word-related society a basic problem is the insecurity arising from the interruption of work income, which, of course, affects not only the worker but those members of his family who are dependent

on his earnings. While a combination of approaches, including group and individual insurance plans and government-sponsored programs, are used in the United States for preventing economic insecurity, the old-age, survivors, and disability insurance program—commonly called social security—is the basic mechanism for preventing insecurity arising from interruption in income from work.

Social security is a social insurance system under which workers and their dependents are insured against the loss of work income resulting from the worker's death, disability, or retirement. The benefit payments made when that loss occurs are designed to partially replace the earnings that are lost, and thus to help prevent the economic insecurity that would otherwise result.

Necessary in any insurance system—private or social—is some way to measure whether, and the extent to which, the loss insured against has occurred. One of the mechanisms used in the social security program is the retirement test. The assumption underlying this test is that if a beneficiary's earnings from work are below certain limits, the loss of earnings insured against has occurred, wholly or partly.

The same general assumption applies throughout the social security cash benefit programs. The disability insurance part of the program takes into account, in evaluating disability, not only the medical condition of the beneficiary, but also his earnings, if any, from work. If a disabled beneficiary has substantial earnings from actual work activity, he is not considered to have suffered a loss of work income sufficient to call for the payment of benefits even though his physical condition may be indicative of severe disability. In the survivors insurance part of the program a sufficient loss of work income is not considered to have occurred if the earnings of the survivors are above certain limits.

THE PRESENT RETIREMENT TEST

The present retirement test contains four important elements:¹

1. *An annual test.*—Annual earnings from work up to \$1680 are exempt from the test; a beneficiary whose earnings from work do not exceed \$1680 in a year is considered to be fully retired and gets full benefits for the year.

2. *A two-step reduction in benefits if earnings exceed the annual exempt amount.*—One dollar in benefits is withheld for each \$2 of annual earnings between \$1680 and \$2880 and for each \$1 of earnings above \$2880.

3. *A monthly test.*—Regardless of annual earnings, benefits are payable in full for any month in which a beneficiary neither works for wages of more than \$140 nor renders substantial services in self-employment.

4. *An exemption on account of age.*—Beginning with the month in which a person reaches age 72, benefits are payable to him (and to his eligible dependents) regardless of the amount of his earnings.

Each of these elements sounds relatively simple, but when combined and explained to an elderly and perhaps not too well-educated person

¹ These elements apply to beneficiaries living in the United States and to beneficiaries who work outside the United States in employment covered by social security. For beneficiaries working abroad in noncovered employment or self-employment, the test is related to the number of days worked in a month. Under the foreign work test no benefit is payable for any month in which work is performed on 7 or more calendar days. The foreign test is discussed more fully in another part of the report.

they can be very confusing. It is not unlikely that some people who could and would like to work do not do so because they do not understand the conditions under which they can work and still get benefits.

The test applies only to income from work; benefits are payable regardless of income from investments and other nonwork sources—savings, investments, insurance, and the like. To include nonwork income in the earnings counted for retirement test purposes would be contrary to the purpose of a social insurance system—to insure against loss of earnings from work. Income from nonwork sources generally continues after retirement as it did before; retirement cannot be determined by measuring the presence or absence of nonwork income. Moreover, disincentives for the creation of private pension plans and savings for retirement would result from inclusion of nonwork income under the retirement test. Furthermore, doing so would make the retirement test similar to the means test used to determine eligibility for payments under public assistance programs, and would thus tend to subject the social security program to the same sort of criticisms that have been leveled at the assistance programs. The reasons the retirement test has taken its present, somewhat complicated form will perhaps be easier to understand if the considerations that led to the various changes that have been made in it through the years are reviewed.

Under the original Social Security Act, which was enacted in 1935, monthly benefits were not payable for any month in which a worker received covered wages from “regular employment.” This provision was changed by the 1939 amendments before any monthly benefits were paid.

From 1940, when monthly benefits first became payable, through 1950 the test of retirement applied only to earnings from covered employment. During those years, work as an employee in commerce and industry was, generally speaking, the only employment covered by the program. The test was entirely on a monthly basis; the beneficiary got a full benefit for any month in which he earned less than \$15 in covered employment. In 1951 this monthly exempt amount was increased to \$50.

When self-employed people were brought under the program in 1951, the test of retirement for them was put on an annual basis. (This was necessary because it is impossible in many cases for a self-employed person to compute his earnings on a monthly basis.) Specifically, it was provided that a person with self-employment earnings of \$600 or less for the year could get benefits for all months in the year, no matter what his earnings were in any single month. One month’s benefit was withheld for each \$50 (or part of \$50) of earnings above \$600.

One part of the test for the self-employed, however, was placed on a monthly basis even though the earnings were figured over the whole year. No matter how high his annual earnings, a self-employed beneficiary could get a benefit for any month in which he did not render substantial services in his business. This latter provision served three purposes: First, it placed the self-employed beneficiary on a par with the wage earner—despite the fact that he could determine his earnings only on an annual basis—in that he could get a benefit for any month in which he did not work or in which he worked very little. Second, it allowed the payment of benefits to a self-employed beneficiary for months in which he did no work in the year in which he

retired, even though his total earnings for the year were above the exempt amount by reason of work done before retirement. And third, the provision allowed payment of benefits to a person whose self-employment income came, not from work in operating the business, but rather from the investment he had in the business.

Another modification in the test, effective in 1951, exempted people from the retirement test at age 75. This change was made in recognition of the fact that some people continue working to a very advanced age. Without such an age exemption these people might never get benefits even though they had paid social security contributions longer than most people.

In 1952 the monthly exempt amount for wage earners was raised from \$50 to \$75, the annual exempt amount for self-employed people was raised from \$600 to \$900, and the unit of earnings above the annual exempt amount which caused one month's benefits to be withheld was increased from \$50 to \$75.

Two important criticisms relating to the different treatment given to wage earners and self-employed people under the test soon developed. First, a self-employed person could work, say, for three months, earn up to the annual exempt amount, and still get benefits for the whole year, while the wage earner who worked in three months and had the same total yearly earnings had three months' benefits withheld. Second, a person who had both self-employment income and wages was in an unwarrantedly favorable position because he could meet the two tests separately; that is, he could have earnings from self-employment for the year of as much as the annual exempt amount, and also have wages in every month amounting to as much as the monthly exempt amount, and still get all of his benefits for the year. The 1954 amendments removed these two anomalies by providing that earnings from self-employment and wage employment would be combined for retirement test purposes and by providing for an annual exempt amount (\$1,200) for both the self-employed beneficiary and the wage-earner beneficiary. For each \$80 (or fraction of \$80) of earnings above \$1,200, one month's benefit was withheld.

The 1954 amendments also provided that a wage earner could get a benefit for any month in which he earned no more than \$80, regardless of his earnings for the year. This provision was included partly to avoid situations where a worker would not be able to get benefits under the 1954 amendments although he could have gotten them before. The provision also solved the problem of finding a way to pay benefits for the rest of a year when a worker retired in the middle of the year after his earnings were over the exempt amount. Without the monthly test a worker who retired in July, for example, after earning \$2,500 in that year, could not have gotten benefits for any part of the year.

In addition, the 1954 amendments lowered from 75 to 72 the age at which people are exempt from the retirement test.

The 1958 amendments provide that a beneficiary who earned above \$1,200 in a year would not have a benefit withheld for any month in which he earned wages of \$100 or less (rather than \$80 or less as previously provided), making the monthly test of retirement one-twelfth of the annual exempt amount. This change was made in order to improve public understanding of how the test operated. One of the reasons people had found the test difficult to understand was that having

benefits withheld for months in which earnings exceeded \$80 did not seem to be rationally related to the \$1,200 exempt amount. No change was made at the time in the provision under which one month's benefit was withheld for each \$80, or fraction of \$80, of earnings above \$1,200.

In the course of its consideration of the 1958 social security amendments, the Committee on Ways and Means directed the Department of Health, Education, and Welfare to examine and to report on the monthly exempt amount—the provision that allows a person, regardless of his annual earnings, to get a benefit for any month in which he does little or no work. The Department submitted a comprehensive report in 1960 which not only covered this aspect of the test but also re-examined its other provisions.

The report discussed the need for retaining the monthly test of retirement, giving essentially the same reasons that had prompted its inclusion in the law originally. The report pointed out that it would not seem reasonable to require a person to go through the first several months of retirement without getting benefits, that benefits should start as soon as possible after earnings cease, and that the monthly test of retirement makes this possible. Without the monthly test a person who retired at the end of June, for example, after having substantial earnings would get no benefits for the rest of the year, even though he had no earnings in the remainder of the year. With the monthly test, he loses benefits only for the months in which his earnings exceed the monthly exempt amount. The monthly test also makes it possible for the beneficiary who returns to or leaves employment during the year to get benefits for the months in which he does not have substantial earnings from work.

The report also discussed the deterrent to work that then existed because of the provision under which one month's benefit was withheld for each \$80, or fraction thereof, of earnings in excess of the annual exempt amount. Under this provision it was possible for a family to lose a full month's benefit for as little as \$1 in excess earnings. In this situation the family could suffer a substantial loss in total income as a result of earnings from work. The report suggested that the method of adjusting benefits where earnings exceed the annual exempt amount should be changed to insure that earnings above the exempt amount would not result in a decrease in the combined total income from earnings and benefits.

The 1960 amendments made no change in the monthly test of retirement but did provide a new method of adjusting benefits where earnings exceeded the annual exempt amount. This new adjustment method was along the lines of the proposals included in the report on the retirement test. The amount of benefits to be withheld was to be in proportion to the amount of annual earnings above \$1,200—\$1 to be withheld for each \$2 of earnings between \$1,200 and \$1,500 and for each \$1 of earnings above \$1,500. This basic method of determining the amount of benefits to be withheld, which was adopted to reduce the deterrent to work which existed under the previous test, is still in effect.

The 1961 amendments extended the band of earnings over which the \$1-for-\$2 adjustment of benefits applied by increasing the ceiling on the band from \$1,500 to \$1,700.

The 1965 amendments made no change in the basic structure of the retirement test. The amendments did, however, raise the annual exempt amount from \$1,200 to \$1,500 (with a corresponding increase in the monthly exempt amount to \$125) and provided that the \$1-for-\$2 adjustment band would apply over a \$1,200 range above the exempt amount—that is, from \$1,500 to \$2,700.

Under the 1967 amendments the annual exempt amount was increased to \$1,680, with corresponding increases in the monthly measure to \$140 and in the ceiling of the \$1-for-\$2 adjustment band to \$2,800.

In summary, the social security law has always contained some provision to assure that benefits will be paid only to people who do not have substantial earnings from work—in effect, a test of retirement.

Any test of retirement for social insurance purposes must be a compromise between two conflicting goals. The principle that social insurance benefits should be paid only to those suffering a loss of work income must be balanced with the need to avoid creating disincentives for those who wish to work. The retirement test, then, must be a compromise between these two objectives. While preventing payment of benefits to people with relatively substantial earnings, the amount of earnings allowed without any withholding of benefits should be high enough to allow those beneficiaries who can work at low-paying or part-time jobs to do so and still get part or all of their benefits.

The retirement test as it stands today prevents the payment of benefits to people with substantial earnings from work, but does not prevent payment merely because a beneficiary has some earnings. It thus does not completely remove incentives to work. The present test must be considered a rough approach to the problem of paying benefits when there has been significant loss of income while avoiding disincentives to work—a problem that is much too complex for any simple solution.

One of the difficulties arises because of the tremendous variation in the circumstances of the beneficiaries. It is questionable whether a retirement test geared to each individual case—e.g., one that would pay benefits to a person who during his working lifetime had a \$20,000-a-year job and after “retirement” is able to make \$5,000 a year as a consultant, while denying benefits to a \$6,000-a-year worker who after retirement manages to pick up something more than \$1,500 at odd jobs—would be accepted by the public.

There is no question that the present test is difficult for most beneficiaries—especially the aged—to understand, both as to operation and as to purpose. One result of its complexity is that it is difficult to administer. Because the operation and purpose of the test are widely misunderstood, administration is made even more difficult.

One of the major factors to be considered in evaluating any proposed change in a social insurance program is the cost of the proposed change relative to its potential benefits and relative to the cost of other possible changes in the program. The cost of total elimination of the retirement test for all beneficiaries, including those under 65, is 0.70 percent of taxable payroll—enough to finance a 7-percent across-the-board increase in social security cash benefits.

HOW MANY PEOPLE ARE AFFECTED BY THE RETIREMENT TEST?

The number of people affected by the retirement test is actually quite small when considered as a percentage of the people who are elig-

ible for benefits. As Table 1 indicates, of the 17.9 million people age 65 and older who are eligible for social security cash benefits on January 1, 1969, only 1.4 million—about 8 percent—have any benefits withheld under the retirement test. While it is not possible to determine the exact number of people who are holding their earnings down because of the test, it appears safe to draw some general conclusions on the basis of information that is available.

TABLE 1.—*Old-age, survivors, and disability insurance: Persons aged 65 and over and eligible for social security cash benefits on Jan. 1, 1969, and number affected by the retirement test in 1968*

[In millions]		Number of persons
U.S. population aged 65 and over, Jan. 1, 1969 ¹	-----	19.8
Persons aged 65 and over, eligible for social security cash benefits on Jan. 1, 1969 ²	-----	17.9
Not subject to the retirement test in 1968 ³	-----	8.3
Subject to the retirement test in 1968 ³	-----	9.6
With no earnings for 1968	-----	6.6
With annual earnings for 1968 below \$1,400	-----	1.2
With annual earnings for 1968 of \$1,400 to \$1,680	-----	.3
With annual earnings for 1968 above \$1,680, but with no benefits for 1968 withheld because of the retirement test ⁴	-----	.1
With annual earnings for 1968 above \$1,680, and with some or all benefits for 1968 ⁵ withheld because of the retirement test	-----	1.4
Some, but not all, benefits withheld because of the retire- ment test	-----	.6
All benefits withheld because of the retirement test	-----	.8

¹ Includes Puerto Rico, Virgin Islands, American Samoa, and Guam. Also includes allowance for underenumeration in the census counts on which the population estimate is based.

² Includes spouses aged 65 and over of workers aged 62-64.

³ Generally, persons who attained age 72 in January 1968 or earlier were not subject to the retirement test in 1968; persons who were under age 72 at the end of January 1968 were subject to the retirement test during some or all months in 1968. An exception to this is a spouse who attained age 72 in January 1968 or earlier of a worker who was under age 72 at the end of January 1968—such spouses were subject to retirement test in 1968.

⁴ These are people who attained age 65 in 1968 and who had no benefits withheld for months in or after the month of attainment of age 65, generally because they had either no earnings or earnings not exceeding \$140 a month in such months.

⁵ As used here, "all benefits for 1968" means all of the benefits for all months in 1968 in which an eligible individual is aged 65 or over.

Of the 17.9 million people age 65 and older who are eligible for benefits, 8.3 million are age 72 and older and thus are not subject to the test. An additional 8.1 million are technically subject to the test but earn less than \$1,680, the annual exempt amount under present law. Among these 8.1 million people, 6.6 million have no earnings at all, and another 1.2 million have earnings of less than \$1,400 a year; almost all of the people in these two groups are probably either unable to earn as much as \$1,680 a year (the present exempt amount) or prefer not to work enough to do so.¹

The remaining 300,000 of the 8.1 million people age 65 and older who are technically subject to the test are earning between \$1,400 and \$1,680 and are getting full benefits. Some of these 300,000—probably most of them—are holding their earnings down, either because they

¹ A 1963 survey made by the Social Security Administration showed that a majority of the aged who were not working—both beneficiaries and nonbeneficiaries—were unable to work. Among those who felt they were able to work, the vast majority did not expect to work and were not interested in working.

do not understand the retirement test or because they want to get all of their benefits; many of them would earn more than they do now if the test were repealed or if the \$1,680 exempt amount were increased. Others among the 300,000 no doubt are earning all that they can earn.

There are about 100,000 persons who attained age 65 in 1968 with 1968 earnings above \$1,680 who had no benefits withheld for months in or after the month of attainment of age 65. Generally, this was so because they had either no earnings or earnings not exceeding \$140 a month in such months.

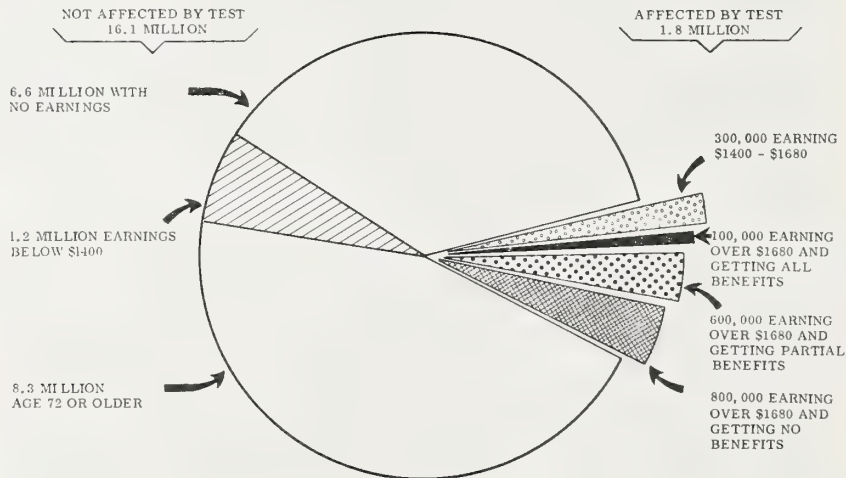
Another group of about 600,000 are earning over \$1,680 and are getting some but not all of their benefits. Presumably most of these people are earning all that they can earn.

The remaining 800,000 people are earning enough over \$1,680 so that no benefits are payable to them. Many of these people undoubtedly are continuing to work and earn as much as they ever did. If the retirement test were eliminated they then could get full benefits without limiting their earnings in any way.

In summary, analysis of the effect of the retirement test on older people indicates that 90 percent of the people eligible for benefits are probably not affected by the test because they are 72 or older or are unable or unwilling to work to any substantial degree. Thus, any change in the test, including its elimination, would not help at all the vast majority of people who are eligible for benefits; the people who would benefit from elimination or liberalization of the retirement test would be those who continue working and earning relatively substantial incomes.

Chart 1

NUMBER OF PEOPLE* AFFECTED BY RETIREMENT TEST IN 1968



*17.9 MILLION ELIGIBLE PEOPLE AGED 65 AND OLDER

(AS OF JANUARY 1, 1969)

III. ANALYSIS OF VARIOUS CHANGES THAT COULD BE MADE IN THE RETIREMENT TEST

THE MONTHLY TEST

Under present law the monthly part of the retirement test permits the payment of benefits, regardless of the amount of annual earnings, for any month in which a person neither earns wages of more than \$140 nor renders substantial services in self-employment. Under this provision a person can have very high earnings in one month and get benefits for the other 11 months of the year. This situation has concerned the Congress, and the Committee on Ways and Means in particular, over the years. The 1960 study of the retirement test was, in fact, prompted by that Committee's interest in the monthly test.

The 1960 report not only presented information on the results of the monthly test as it applied to high wage earners but also considered a special test for people with relatively high earnings. The conclusions were that the monthly test of retirement should be retained and that a separate test for beneficiaries with high earnings would add further complexities to an already complex provision and would, solely on the basis of high earnings over a short time, prevent the payment of benefits to people who were actually retired.

A major function of the monthly test is to make possible the payment of benefits to a retired worker beginning with the first month of his retirement. This allows payments to begin as soon as possible after earnings cease—when the need for benefits arises. Removal of the monthly test would make it impossible in many cases to pay benefits promptly upon retirement. So far as is known, no other retirement system operates in such a way.

The following are examples of what would occur if the monthly test were eliminated:

(a) A person retires at the end of August 1968 after being paid \$4090 in that year. His social security benefit amount is \$150. Because of the monthly test of retirement, his benefit payments begin with September. If there were no monthly test, the first benefit for this person would be paid February 3, 1969, for January of that year. Thus he would have been retired for 5 months before he got a social security benefit.

(b) Since people move in and out of employment after reaching retirement age, the problem is not confined to the year of initial retirement for each beneficiary. A person getting \$135 a month in benefits has a chance to take a job in January paying \$150 a week, and does so, thinking he will be able to keep on working. He no longer gets benefits and spends most or all of his earnings for current living expenses. In June his employer goes out of business, and he is unable to get another job. Since in the first 6 months of the year he has earned \$3900, he would not be able to get benefits for the next 6 months if there were no monthly test of retirement—and he would have no earnings.

On the other hand, there are instances in which the monthly test permits the payment of benefits to some who have not really altered

their work pattern and thus are not really retired. These are people whose work is usually carried on during only a part of the year—people like construction workers, teachers, and resort owners. The following are examples of how this can occur:

(a) A teacher who over all of her working lifetime has worked a 9- or 10-month school term and used the summer for vacation applies for social security retirement benefits at age 65 but does not alter her preretirement work pattern. Under present law she may be eligible for 2 or possibly even 3 months' benefits during the summer.

(b) The self-employed owner of a resort earned his livelihood before age 65 by working 8 months of the year. He did no work from October through January. At age 65 he applies for social security benefits and continues to work his usual 8 months in the year. Without altering his preretirement pattern of work, he can get social security benefits for the 4 months when he does not work.

No good reason related to the purpose of the social security program exists for paying benefits to nonretired teachers or seasonal workers for months in which they do not work. These people have not incurred any loss of income. On the other hand, many workers whose normal work is seasonal do work at other jobs during their off season—in fact, for many this is their normal way of life—and if such a person gives up one of his jobs in his old age he has partially retired. One of the major difficulties, then, is how to distinguish, among people who have done seasonal work, those who are in effect partially retired from those who are not. There is also a question of public acceptance; granted that there is dissatisfaction with the test in its present form, it could be very difficult to explain why, where two people were in identical situations, one could get benefits and the other could not.

Nevertheless various alternatives have been developed to deal with the situation in which a person with relatively high earnings for a few months of the year is able to get retirement benefits for the balance of the year. While it would be possible to solve this problem by establishing a retirement test entirely on an annual basis, the examples given above suggest that any such solution would be undesirable. The nearest approach to a satisfactory alternative is outlined below; the Department does not, however, recommend its adoption.

A SEPARATE RETIREMENT TEST FOR PEOPLE WITH RELATIVELY HIGH EARNINGS

This alternative test would add, on top of the present retirement test, a provision that, no matter how little a person worked in a year, \$1 in benefits would be withheld for each \$2 in annual earnings above an amount equal to the ceiling on earnings that are subject to social security contributions and are counted in figuring benefits (now \$7,800). This provision would prevent a drop in income as a result of an increase in earnings above the ceiling for that year. At the same time it would avoid the payment of benefits to people whose earnings were very high.

The following examples illustrate how this alternative would work:

(a) A famous entertainer retires at age 65 in 1969 and becomes eligible for maximum retirement benefits of \$160.50. He decides to

make a single appearance after his retirement, for which he is paid \$12,000. Under the monthly test in present law he can collect social security benefits for 11 months of the year (\$1,765.50) because he has had no earnings in those months. Under the alternative, an amount equal to one-half of his earnings in excess of \$7,800 (\$2,100) would be withheld from the benefits that would otherwise be payable to him. Since \$2,100 exceeds the \$1,765.50 in benefits otherwise payable, he would receive no benefits for the year.

(b) A corporation executive retires at age 65 at the end of February 1969, having earned \$11,000 in the first two months of the year. Under present law he can collect social security benefits for 10 months of the year (\$1,605, again, as in paragraph *a* above, assuming maximum retirement benefits). Under the alternative, an amount equal to one-half of his earnings in excess of \$7,800 (\$1,600) would be withheld from the benefits otherwise payable. He would receive only \$5 in social security benefits for the balance (10 months) of the year in which he retired.

Table 2 gives other examples of the benefits that would be payable under this alternative.

TABLE 2.—ANNUAL BENEFITS PAYABLE UNDER PRESENT LAW AND UNDER A PROPOSAL TO MODIFY THE MONTHLY TEST ¹(EXAMPLES ASSUME BENEFICIARY IS GETTING A MONTHLY RETIREMENT BENEFIT OF \$160.50)

Annual earnings	Annual benefits that would be payable if the number of months worked were—										
	1	2	3	4	5	6	7	8	9	10	11
Present law: \$7,800 ²	\$1,765.50	\$1,605	\$1,444.50	\$1,284	\$1,123.50	\$963	\$802.50	\$642	\$481.50	\$321	\$160.50
Proposal:											
\$7,800	1,765.50	1,605	1,444.50	1,284	1,123.50	963	802.50	642	481.50	321	160.50
\$8,200	1,565.50	1,405	1,244.50	1,084	923.50	763	602.50	442	281.50	121	160.50
\$8,600	1,365.50	1,205	1,044.50	884	723.50	563	402.50	242	81.50	-----	-----
\$9,000	1,165.50	1,005	844.50	684	523.50	363	202.50	42	-----	-----	-----
\$9,400	965.50	805	644.50	484	323.50	163	2.50	-----	-----	-----	-----
\$9,800	765.50	605	444.50	284	123.50	-----	-----	-----	-----	-----	-----
\$10,200	565.50	405	244.50	84	-----	-----	-----	-----	-----	-----	-----
\$10,600	365.50	205	44.50	-----	-----	-----	-----	-----	-----	-----	-----
\$11,000	165.50	5	-----	-----	-----	-----	-----	-----	-----	-----	-----
\$11,400	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----

¹ \$1 in benefits would be withheld for each \$2 in annual earnings above \$7,800 from months protected by the monthly test under present law; no other change would be made in present law.

² The benefits appearing on this line are the minimum amounts payable under the provisions of present law regardless of how much a beneficiary earns in the year; in cases where the worker has low earnings for the year the benefits payable for the year may be somewhat higher.

It should be pointed out that the alternative would further complicate an already quite complicated provision. And many of the people who would be adversely affected by the provision would be people who are essentially retired within the normal meaning of the word.

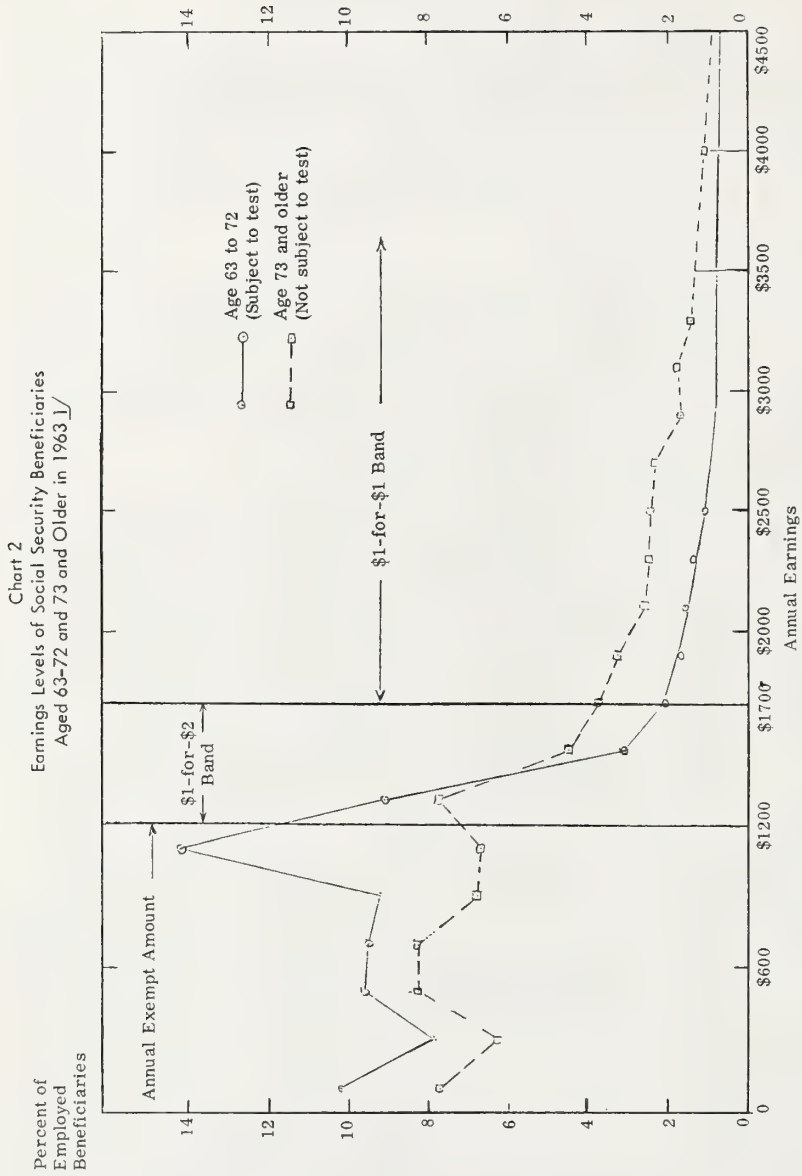
THE ANNUAL EXEMPT AMOUNT

The annual exempt amount—the amount of earnings a person can have in a year without having any benefits withheld—has, over the years, been the element of the retirement test that has elicited the greatest congressional interest. During the 90th Congress, 103 bills were introduced to increase the exempt amount. The interest of the general public has also centered on increasing the annual exempt amount. This provision of the test has been subject to greater pressures for change than any other.

The annual exempt amount has been increased from \$600 in 1951, when an annual exempt amount was first used, to \$1,680 in 1968. Yet, since 1955 the exempt amount has not increased relative to earnings, and in fact has decreased in periods between statutory increases in the amount. Those statutory increases had the effect of bringing the amount back to about 30 percent of the median earnings of male workers. Table 3 shows the relationship between the annual exempt amount and the median annual earnings of all male workers in covered employment in 1940 and in all the years since 1951.

It is impossible to determine the exact amount of earnings that best distinguishes between retirement and nonretirement at a given time. The retirement test, while intended to prevent the payment of benefits to people who have substantial earnings from work, is also intended to interfere as little as possible with incentives to work. Studies indicate that the annual exempt amount has a significant effect on incentives to work. Chart 2, based on a one-percent sample of beneficiaries under the 1963 retirement test (which had a \$1,200 annual exempt amount), illustrates rather forcefully the fact that a substantial number of beneficiaries subject to the test limited their earnings to the annual exempt amount and thus got their full benefits for the year. In contrast, no significant number of people among those not subject to the test—those age 73 and older—was clustered at any particular earnings level. It would appear, then, that the annual exempt amount is a significant factor for many people in planning their work for the year. Probably many people simply do not understand the application of the test to earnings above the exempt amount. Others are no doubt reluctant to earn more than the exempt amount since \$1 in benefits is withheld for each \$2 of earnings in the adjustment band and people consider themselves to be working at half pay in this range. There seems to be no doubt that the greatest deterrent to work occurs at the exempt amount.

A further point is that as the exempt amount is raised, more people can continue working for substantially the same wages after they start getting benefits as they were earning before their benefits began and still get some or all benefits for the year. This happens to some extent under present law, of course, but if the exempt amount were increased it would happen in more cases. For example, a man who qualifies for a benefit based on average yearly earnings of \$4800 and



1/ Retirement test provided a \$1,200 annual exempt amount with \$1 in benefits withheld for each \$2 of earnings between \$1,200 and \$1,800 and \$1 for each \$1 of earnings above \$1,800.

who retires at age 65 in 1969 could—under an annual exempt amount of \$2400 and a \$1-for-\$2 reduction band to \$3600—earn \$4000 a year after retirement and still get \$843.20 in benefits for the year. His income would actually be higher than before he “retired”, and after taxes, this difference would be accentuated, since the \$843.20 in retirement benefits would not be subject to Federal taxes.

Increasing the annual exempt amount to \$2400 would cost 0.29 percent of taxable payroll. Increasing it to \$3600, with a \$1-for-\$2 reduction band to \$4800, would cost 0.64 percent of taxable payroll—about the same cost as abolition of the test for those age 65 and older and enough to finance a general benefit increase of more than 6 percent.¹ Yet the majority of social security beneficiaries are not working, have low earnings, or are age 72 or older. Most of these would not be helped at all by an increase in the exempt amount.

This is not to say, though, that it would be unreasonable to increase the exempt amount from time to time as earnings levels rise. This has been done by the Congress over the years. Based on anticipated increases in earnings in 1969–70, it is estimated that an increase of the annual exempt amount to \$1800 effective in 1970 would maintain the same relationship that existed in 1968 between median annual earnings and the annual exempt amount. An \$1800 annual exempt amount with a \$1200 \$1-for-\$2 adjustment band above that amount would cost 0.05 percent of taxable payroll; an \$1800 exempt amount with an adjustment of \$3-for-\$4 above the \$1-for-\$2 band would cost 0.07 percent of taxable payroll.

AUTOMATIC ADJUSTMENT OF THE EXEMPT AMOUNT

It would be possible, of course, to establish an exempt amount that would not become outdated if earnings levels continue to rise in the future as they have in the past. This could be done by providing for an automatic adjustment of the exempt amount to rises in earnings levels. If the exempt amount were increased under such a provision, a corresponding increase should also be made in the monthly test and in the \$1-for-\$2 adjustment band. Such a change would not require new financing. As earnings levels rise, income to the system increases more than the corresponding benefit liabilities, and the excess of income would more than cover the cost of adjusting the exempt amount.

Table 3 shows how the median earnings of all male workers in employment covered by the social security program have increased since 1940, as well as estimated amounts for future years. During some periods in the past, the exempt amount has not been increased frequently enough to adequately reflect increases in earnings levels. For example, when the \$1200 annual exempt amount became effective in 1955, it was equal to about 36 percent of median annual earnings of male workers in covered employment. This \$1200 amount was not changed until after 1965, when the relationship had dropped to about 26 percent.

¹ If the test were abolished for all social security beneficiaries, rather than only for those age 65 and over, the cost would be 0.70 percent of taxable payroll—enough to finance a benefit increase of 7 percent.

TABLE 3.—COMPARISON OF MEDIAN EARNINGS OF ALL MALE WORKERS IN COVERED EMPLOYMENT WITH EXEMPT AMOUNT OF THE RETIREMENT TEST IN SELECTED YEARS

Year	Median annual earnings of all male workers	Annual exempt amount	Exempt amount as percent of median earnings of all male workers
1940	\$935	¹ \$179.88	19.2
1951	2,838	600.00	21.1
1952	3,046	900.00	29.5
1953	3,275	900.00	27.5
1954	3,263	900.00	27.6
1955	3,315	1,200.00	36.2
1956	3,546	1,200.00	33.8
1957	3,538	1,200.00	33.9
1958	3,516	1,200.00	34.1
1959	3,783	1,200.00	31.7
1960	3,879	1,200.00	30.9
1961	3,936	1,200.00	30.5
1962	4,132	1,200.00	29.0
1963	4,266	1,200.00	28.1
1964	4,480	1,200.00	26.8
1965	4,680	1,200.00	25.6
1966	4,960	1,500.00	30.2
1967 ²	² 5,250	1,500.00	28.6
1968	5,500	1,680.00	30.5
1969	5,720	1,680.00	29.4
1970	5,980	1,680.00	28.1
1975	7,440	1,680.00	22.6

¹ No annual exempt amount was provided before 1951. The figure shown is 12 times \$14.99 the monthly exempt amount in effect through 1950.

² Figures for years beginning with 1967 are based on estimates of the Social Security Administration.

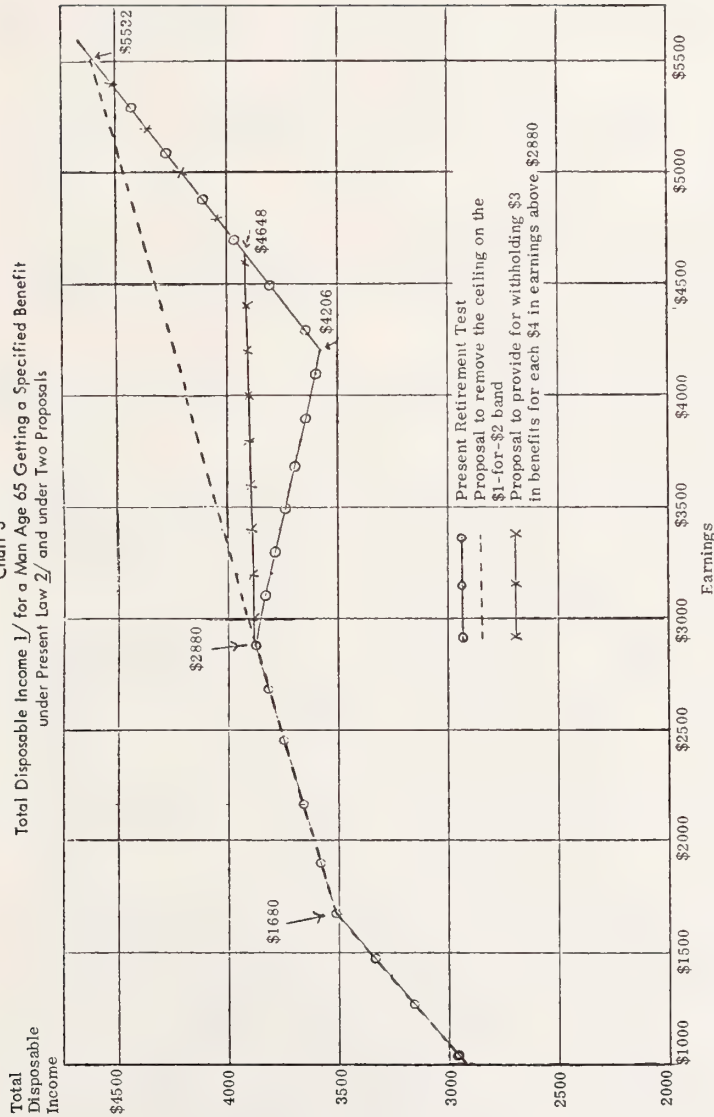
ADJUSTMENT OF BENEFITS WHERE EARNINGS EXCEED THE ANNUAL EXEMPT AMOUNT

Prior to the 1960 amendments, one month's benefit was withheld for each \$80 (or portion thereof) of earnings above the annual exempt amount. Under this method of adjusting benefits above the annual exempt amount, it was possible for a family to have considerably less in total income as a result of the worker's employment, since an amount as small as \$1 could cause a full month's benefits for the family to be withheld. As already noted, this situation was examined in the 1960 retirement test study and recommendations for a change were made. As a result, the 1960 social security amendments provided that \$1 in benefits would be withheld for each \$2 of earnings between the \$1,200 annual exempt amount and \$1,500, and for each \$1 of earnings above \$1,500. This is the basic adjustment method which is used today.

While the 1960 change removed an inequity in the retirement test, it has not been entirely satisfactory. A person's total income can still be reduced because he works and has earnings beyond a given amount, since for each \$1 in taxable earnings above \$2,880, \$1 in tax-free benefits is withheld. Thus, a man who works and earns slightly above \$2,880 will actually have less in total disposable income (benefits plus earnings after taxes) than if he chooses to stop working when he has earned \$2,880.

Chart 3 illustrates the effect of the adjustment band on the disposable income of a man getting a retirement benefit of \$160.50—the maximum benefit amount payable to a man retiring at age 65 in 1969. It should be pointed out that the example shown in the chart does not take account of State or local taxes nor expenses incidental to work. Also, the 10-percent increase in Federal income taxes, because of its temporary nature, has not been included. These factors would further reduce the amount of disposable income.

Chart 3
Total Disposable Income 1/ for a Man Age 65 Getting a Specified Benefit
under Present Law 2/ and under Two Proposals



1/ Total disposable income is social security benefits payable after a retirement test is applied, plus wages after social security contributions (using 1969 rates) and Federal income taxes are withheld. The income tax is computed for a 65 year old single man with standard deductions and does not include the 10 percent surtax. The social security benefit used is \$160.50, the maximum benefit payable to a male worker who is age 65 in 1969.

2/ Under present law, the amount of earnings a beneficiary can have in a year and still get full benefits is \$1680. If earnings exceed \$1680, \$1 in annual benefits is withheld for each \$2 of earnings between \$1680 and \$2880 and for each \$1 of earnings above \$2880.

Extending somewhat the upper limit of the \$1-for-\$2 reduction band would alleviate the situation, since fewer people would be adversely affected, but it would not eliminate the possibility of a person's having less total disposable income as a result of working. The effect of such a change would merely be to raise the point at which the anomaly occurs. If the \$1-for-\$2 band in present law were extended from \$1,200 to, say, \$1,800, the worker with low or average earnings would gain by working, but the worker with higher earnings would not.

To eliminate the problem, it would be necessary to provide for applying another adjustment ratio for earnings above \$2,880—for example, withholding \$3 in benefits for each \$4 of earnings above \$2,880, or extending the \$1-for-\$2 range to all earnings above the exempt amount. A \$3-for-\$4 adjustment for earnings above \$2,880 would cost 0.02 percent of taxable payroll. Such a change would generally assure that a person who had earnings above \$2,880 would break even, rather than suffer a reduction in disposable income as under present law. Chart 3 shows the effect a \$3-for-\$4 reduction would have on disposable income.

On the other hand, as illustrated by Chart 3, if the present \$1-for-\$2 adjustment band were extended without limit, a person would almost always be assured of an increase in disposable income as a result of working.

Since the same adjustment would apply to any amount of earnings, a straight \$1-for-\$2 provision would make the test somewhat less complicated than it is now. However, it would result in benefit payments to some people with relatively high earnings. This change would cost 0.03 percent of taxable payroll.

Liberalizing the adjustment band either by extending the \$1-for-\$2 band or adding a \$3-for-\$4 band on top of it will not help people with low annual earnings—earnings under \$2,880. It seems advisable, then, that an increase in the annual exempt amount, which would benefit those among the lower-paid who can work, be considered in conjunction with any change in the adjustment band.

As discussed in the section on the annual exempt amount, there is a strong tendency on the part of beneficiaries not to earn above the annual exempt amount unless they have substantial earnings above that amount. Chart 2 indicates that the annual exempt amount appears to have much greater significance for beneficiaries than the other provisions of the retirement test. It seems unlikely that any significant percentage of beneficiaries would be induced to substantially increase their earnings above the exempt amount regardless of any change made in the provisions for determining the amount of benefits to be withheld above the exempt amount. The basic reason for making such a change is to assure that a person's income would generally not decrease as a result of working. Withholding \$3 in benefits for each \$4 in earnings above the upper limit of the \$1-for-\$2 band would be a relatively inexpensive way (0.02 percent of taxable payroll) to assure that a person's income would generally not be decreased as a result of his work.

THE AGE AT WHICH THE TEST CEASES TO APPLY

The Social Security Amendments of 1950 modified the retirement test to provide that people age 75 and older could get benefits regardless of the amount of their earnings; prior to that time the test was applied without regard to age. The age was reduced to 72 by the 1954 amendments. Although congressional interest in changing the retirement test has focused on an increase in the annual exempt amount, there has also been some congressional interest in lowering the age at which people are not subject to the test.

The reason the retirement test no longer applies when a person reaches an advanced age is stated in the report of the Senate Committee on Finance on the Social Security Amendments of 1954, as follows:

Under present law, persons age 75 and over are exempted from the retirement test primarily as a means of assuring some return on contributions for people who continue working to a very advanced age and who would otherwise draw very little, if any, payment under the system.

And, of course, since most people do not work to these ages, suspending the test at age 75 and even at age 72 was relatively inexpensive. A further lowering of the age at which a person is exempt from the test might reduce somewhat the negative reaction that the test engenders. The retirement test is sometimes interpreted to mean that the Government does not want social security beneficiaries to work, and many people, including some who are not really affected by the test, resent what they consider an unwarranted restriction. If the age at which benefits could be paid regardless of earnings were lowered from age 72, there would perhaps be less objection on this ground.

On the other hand, the lower the age at which benefits are paid regardless of earnings, the more people there will be who are working and getting benefits, and therefore, of course, the higher the cost. To lower from 72 to 70 the age at which a person would be exempted from the test would cost 0.11 percent of taxable payroll; to lower it from 72 to 68 would cost 0.26 percent.

On balance, the Department believes that, because of the substantial additional cost that would be incurred, a proposal to lower the age at which the test no longer applies should have low priority.

A VARIABLE EXEMPT AMOUNT

Another possible approach to amending the retirement test would be to provide a variable exempt amount. Several bills were introduced by members of the 90th Congress to provide a higher annual exempt amount for people who get low benefits.

The intent of this type of proposal is to allow a person who has been dependent on covered earnings over all or most of his working lifetime, and who because of low earnings is getting low benefits, to earn more without having any benefits withheld than a person getting high benefits. Since the workers getting benefits in the lower ranges presumably have less margin for reduction in their income than do those getting higher benefits, it has been argued that those getting low benefits should be allowed more leeway to supplement their benefits than those who get high benefits.

One proposed change would provide that the annual exempt amount would be equal to \$2,880 (the point in present law at which the withholding of \$1 in benefits for each \$1 in earnings begins to take effect) less the annual benefit amount. If the exempt amount determined in this manner were less than the \$1,680 annual exempt amount in present law, the provisions of present law would apply. The \$1-for-\$2 band would extend over the first \$1,200 above the annual exempt amount as determined above, and \$1 in benefits would be withheld for each \$1 of earnings thereafter.

This proposal would, in effect, provide a variable exempt amount which would always be higher than the exempt amount under present law for people getting benefits of less than \$1,200 a year; for those getting benefits of \$1,200 a year or more, there would be no change from present law. A man with a monthly benefit amount of \$100 (\$1,200 a year) could, as under present law, have earnings of \$1,680 in a year (\$2,880 minus \$1,200) before any benefits would be withheld. A man who had a monthly benefit of \$90 (\$1,080 a year) could have earnings of \$1,800 (\$2,880 minus \$1,080) before any benefits would be withheld.

The basic objection to this type of change is that it would probably not accomplish its purpose. Since social security benefits are based on average earnings, most people who have worked regularly in covered employment during most of their working lifetime and who get low benefits do so primarily because they had low earnings before retirement. But if they could not earn more before retirement, it is quite unlikely that they could do so afterwards. A man aged 65 retiring in 1969 whose benefit was based on average annual earnings of \$1,200 would get benefits of \$858 a year; he would, under this proposal, have earnings up to \$2,022 (\$2,880 less \$858) and still get all of his benefits for the year; but if he could earn \$2,000 a year, he would in all likelihood have been earning that much before retirement. It seems reasonable to assume that most people who continue to work after "retirement" will not earn more than they earned before, in which case the proposal would be of no help to them. Among those for whom this particular variable exempt amount would be of no benefit are people whose average annual earnings are at the level of \$3,328, the lowest wage now payable to a full-time worker under the minimum wage law.

The people who would benefit under the proposal would generally be those whose major employment was in noncovered work—Federal employees, for example—and who qualified for low social security benefits through part-time work. They could, after retirement from their major employment, get social security benefits—and probably other public retirement benefits—and at the same time work for substantial earnings.

If a variable exempt amount were provided, it would seem more logical to allow a person who had high earnings before retirement to earn more and get full social security benefits than a person who had low earnings before retirement, since a high earner who significantly cuts his preretirement earnings—say to 25 percent—might be considered as retired as a low earner who cuts his preretirement earnings by the same percentage. For example it could be argued that a person who reduces his preretirement earnings of \$20,000 per year to \$5,000 per year is just as retired as a person who reduces his preretirement earnings from \$4,000 to \$1,000. But the general public would find it hard to under-

stand, even though it does make sense in a wage-related system, why people getting higher social security benefits could earn more than those getting lower benefits. In effect, there would appear to be a special retirement test favoring one group of beneficiaries—the more fortunate group—over the less fortunate group.

The Department recommends against providing any type of variable exempt amount under the retirement test.

SPECIAL PROVISIONS FOR CERTAIN GROUPS

Proposals under which certain employee groups or specific categories of beneficiaries would be exempt from the retirement test have been made, and a few bills to exempt specific groups from the test were introduced in the last Congress. Groups which have been suggested for exemption include widowed mothers with children in their care and people who work in certain jobs that contribute to the general welfare or who are in labor-short industries.

There is no doubt that in many cases a widowed mother with children in her care, who upon the death of the father of the family is faced with added responsibilities and less-than-normal income, has problems meeting her living expenses. It should be noted, though, that even if the widowed mother works, the children will continue to get their benefits. Moreover, the economic situation of most other social security beneficiaries is in general no better than that of widowed mothers. Although it would be relatively inexpensive to eliminate the test for any small group—for example, 0.04 percent of taxable payroll for mothers—it would be difficult to justify eliminating the test for that group and not doing the same for other groups, many of whom are faced with equal or greater financial difficulties.

Proposals that certain occupational groups be exempted from the test are made on the basis that they would help alleviate manpower shortages in occupations that are essential to the national interest. The idea, of course, is that people who work in hard-to-fill occupations, such as teaching and work in the field of health services, should have their income from such jobs excluded from the retirement test in order that they will continue to work.

The task of determining which occupational groups should be exempted from the retirement test would be a difficult one, and there does not appear to be any agreement in this area. Furthermore, it is questionable whether exemption from the retirement test would have any really significant effect on filling such jobs. People employed in occupations that were exempted from the retirement test would undoubtedly be encouraged to continue work after retirement age, since they could draw full benefits in addition to their regular work income. But it would be extremely difficult, if not impossible, to determine to what extent exemption from the test would influence workers of retirement age who were not employed in these hard-to-fill positions to seek training in these occupations, or to what extent opportunities would be available to them. A \$3-for-\$4 band in place of the \$1-for-\$1 band in present law would assure that a beneficiary would not have less in disposable income as a result of working for earnings above \$2,880 than if he limited his earnings to \$2,880 and therefore would not discourage people from continuing to work. At the same time it would not favor one group of beneficiaries over others.

IV. A DELAYED RETIREMENT CREDIT

As mentioned earlier, the Congress specifically directed the Department, as a part of its study of the retirement test, to examine proposals to pay increased retirement benefits to people who delay retirement beyond age 65.

Under the provisions of present law a worker's retirement benefit is based on his average monthly earnings over a specified number of years; the period used is generally 5 less than the number elapsing after 1950, or age 21, if later, and up to the year in which the worker reaches age 65 (62 for a woman). The law also provides that if he has years of higher earnings after age 65 (62 for a woman), these earnings can be substituted for years of no earnings or years of lower earnings before that age in figuring his average monthly earnings, thereby providing for him a higher benefit amount than would otherwise be possible. Thus a worker who has higher covered earnings after retirement age than he had in earlier years does get higher social security benefits because of his earnings after retirement age. This provision is especially helpful for people who earn above the maximum amount creditable under social security—at present \$7800 a year; when the amount of earnings that can be credited toward benefits is increased, a person continuing to work after 65 (62 for a woman) for annual earnings of more than were previously covered can substitute these years for earlier years in which less of his earnings could have been credited.

But some people who postpone retirement beyond age 65—or who interrupt their retirement to return to work—get benefits no larger than if they had retired at age 65, despite their additional contributions and the fact that they have foregone benefits for some months. Many people resent this. It has been argued that as a matter of equity people who work after 65 should get higher benefits when they do retire.

The argument for providing a delayed retirement credit as a matter of equity carries weight only when it is used relative to two people of the same age who began working under the program at the same time. Not all people who continue to work after age 65 have contributed for a longer period than those who stop work at 65. A person can get a full-rate benefit even though he had no work in covered jobs before 1956. With a delayed retirement credit he would get additional benefits if he worked after age 65 even though he had worked under social security for relatively few years; yet a person of the same age who had contributed to the program since 1937 but who had to retire at age 65 would not get any additional benefits.

A major consideration regarding a delayed retirement credit is its cost. If the credit were large enough to compensate the average person who works beyond age 65 for benefits he would have been paid if he had retired at age 65, the benefit amount payable would have to be increased by approximately 8 percent for each year of delayed retirement. The cost of paying these higher benefits to people age 65 and over would be about 0.65 percent of taxable payroll—the same as the cost of abolishing the retirement test for people age 65 and older. A credit of 4 percent for each year of delayed retirement would cost 0.32 percent. Table 4 gives examples of the benefits that would be payable under various delayed retirement credit proposals.

The objective of paying higher social security benefits for all those who work after age 65 has merit, although there are arguments against it. To do so would incur a high cost, yet those most likely to be affected to any significant degree by the credit would be people who were able to get, or keep, jobs that pay rather substantial wages. In a program designed to provide a partial replacement of lost earnings there does not seem to be any good rationale for providing, at considerable expense, a higher replacement for people who are able to continue working or to get jobs after age 65 than can be paid to people who have had to quit working at age 65. On the other hand, it is true, of course, that providing additional benefits for continued work after age 65 would increase public acceptance of the program, especially among people who work after age 65. The Department believes, though, that any delayed retirement credit should have a relatively low priority until benefit levels have been substantially improved.

TABLE 4.—EXAMPLES OF MONTHLY BENEFITS PAYABLE TO A MAN AGE 65 IN 1968 UNDER PRESENT LAW AND UNDER 4 PROPOSALS FOR A DELAYED RETIREMENT CREDIT¹

Year of retirement	Monthly benefit amount				
	With annual credit equal to ² —				
	Present law	3 percent (a)	4 percent (b)	6 percent (c)	8 percent (d)
1968	\$156.00				
1969	162.80	\$167.70	\$169.40	\$172.60	\$175.90
1970	168.40	178.60	181.90	188.70	195.40
1971	174.10	189.80	195.00	205.50	215.90
1972	179.70	201.30	208.50	222.90	237.20
1973	184.20	211.90	221.10	239.50	257.90
1974	189.90	224.10	235.50	258.30	281.10
1975	195.00	236.00	249.60	276.90	304.20

¹ Examples assume maximum earnings creditable for social security purposes each year. From 1937 to 1950, the maximum creditable earnings were \$3,000. This amount was raised to \$3,600 in 1951, to \$4,200 in 1955, to \$4,800 in 1959, to \$6,600 in 1966, and to \$7,800 beginning in 1968. Examples also assume that the man retires in January of the year shown.

² Under proposal (a) benefits computed under the existing provisions of the law would be increased by $\frac{1}{4}$ of 1 percent for each month for which a full benefit is withheld under the retirement test; under (b) by $\frac{1}{3}$ of 1 percent; under (c) by $\frac{1}{2}$ of 1 percent, and under (d) by $\frac{3}{4}$ of 1 percent. The latter is the amount needed to fully compensate a worker for benefits that could have been paid if he had not worked after reaching age 65.

V. THE FOREIGN WORK TEST

Prior to 1955, the retirement test applied only to earnings in work covered under the social security program; people who worked in non-covered employment could continue to draw their social security benefits regardless of their earnings. Thus, most beneficiaries working outside the United States were not subject to the retirement test. The 1954 amendments provided that earnings from any type or employment or self-employment in the United States, whether or not covered, were to be taken into account in determining whether benefits should be withheld. However, earnings from noncovered work outside the United States were excluded in determining total earnings for the annual retirement test. Instead, a separate test was devised for beneficiaries who worked in noncovered jobs outside the United States. Under this test benefits are withheld for any month in which a beneficiary engages in noncovered remunerative activity (either employment or self-employment) outside the United States on 7 or more different calendar days.

The chief reason for having a time test was that differences in the values of foreign currencies would have made it practically impossible to maintain parity between domestic and foreign beneficiaries if a money test were used. Whereas a specific amount of earnings derived from a particular trade in one country might represent full-time work, the same earnings in another country might be indicative of only part-time employment.

The domestic retirement test, phrased as it is in terms of dollars, has been updated over the years to bring it into accord with changing economic conditions. There obviously has not been the same need to update the 7-day foreign work test. Nevertheless the question has been raised whether improvements might be made in the foreign work test. Work as an employee under this test has been interpreted to include not only the actual performance of services, but the employment relationship itself. Thus an employee is considered to be working if, under an employment relationship, the performance of services is contemplated or the employee has agreed to be available for work.

For those people who work and earn substantial amounts, the 7-day work test is reasonably equitable. There are, however, certain categories of beneficiaries who, although they earn very little, are adversely affected by the 7-day test—apprentices and small farmers, for example. The Department is continuing to study these situations to determine what, if any, changes should be made in the provisions of the foreign work test; it has no proposals to make at this time.

APPENDIXES

APPENDIX A

COST OF RETIREMENT TEST PROPOSALS

Annual exempt amount	Proposal		Cost as percent of payroll
	Monthly test	Adjustment for earnings above exempt above	
1. \$1,740.....	\$145	\$1 for \$2 for 1st \$1,200 (to \$2,940), \$1 for \$1 above \$2,940.	0. 03
2. \$1,800.....	150	\$1 for \$2 for 1st \$1,200 (to \$3,000), \$1 for \$1 above \$3,000.	. 05
3. \$1,800.....	150	\$1 for \$2 for 1st \$1,200 (to \$3,000), \$3 for \$4 above \$3,000.	. 07
4. \$1,800.....	150	\$1 for \$2 above \$1,800.....	. 08
5. \$2,100.....	175	\$1 for \$2 for 1st \$1,200 (to \$3,300), \$1 for \$1 above \$3,300.	. 17
6. \$2,400.....	200	\$1 for \$2 for 1st \$1,200 (to \$3,600), \$1 for \$1 above \$3,600.	. 29
7. \$3,600.....	300	\$1 for \$2 for 1st \$1,200 (to \$4,800), \$1 for \$1 above \$4,800.	. 64
8. Eliminate test for mothers.....			. 04
9. Eliminate test for children.....			. 01
10. Eliminate test at age 70.....			. 11
11. Eliminate test at age 68.....			. 26
12. Eliminate test at age 65.....			. 65
13. Eliminate test entirely.....			. 70

APPENDIX B

Cost of delayed retirement credit proposals

<i>Proposal</i>	<i>Cost as percent of payroll</i>
1. Delayed retirement credit of $\frac{1}{4}$ of 1 percent of the worker's benefit amount for each month retirement is delayed beyond age 65. Dependents' benefits would be increased proportionately-----	0. 24
2. Same as No. 1 except credit is $\frac{1}{3}$ of 1 percent for each month-----	. 32
3. Same as No. 1 except credit is $\frac{1}{2}$ of 1 percent for each month-----	. 48
4. Delayed retirement credit large enough to compensate for the full amount of benefits foregone by delaying retirement beyond age 65 ($\frac{2}{3}$ of 1 percent for each month), with corresponding increase in dependents' benefits-----	. 65

APPENDIX C

DRAFT OF PROPOSED LEGISLATION

A BILL To amend title II of the Social Security Act to increase the amount of earnings permitted each year without deductions from benefits thereunder

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) paragraphs (1), (3), and (4) (B) of section 203(f) of the Social Security Act are each amended by striking out "\$140" and inserting in lieu thereof "\$150 or the exempt amount (determined as provided in paragraph (8) of this subsection)."

(b) Paragraph (1) (A) of section 203(h) of such Act is amended by striking out "\$140" and inserting in lieu thereof "\$150 or the exempt amount (determined as provided in paragraph (8) of subsection (f) of this section)".

(c) Paragraph (3) of section 203(f) of such Act is further amended by striking out "except that of the first \$1,200 of such excess (or all such excess if it is less than \$1,200), an amount equal to one-half thereof shall not be included." and inserting in lieu thereof the following: "except that there shall not be included in such excess—

"(A) 50 percent of the first \$1,200 of such excess (or 50 percent of all of such excess if it is less than \$1,200), and

"(B) (if such excess is greater than \$1,200) 25 percent of the difference between such excess and \$1,200."

(d) Subsection (f) of section 203 of such Act is amended by adding at the end thereof the following new paragraph:

"(8) (A) Between July 1 and November 1 of 1971 and each odd-numbered year thereafter, the Secretary shall determine and promulgate the exempt amount (as defined in subparagraph (B)) for each month in the taxable years ending (i) in the next succeeding odd-numbered year and (ii) in the year following the year specified in clause (i).

"(B) The exempt amount for each month of a particular taxable year shall be whichever of the following is the highest:

"(i) the product of \$150 and the ratio of (I) the average taxable wages of all persons for whom taxable wages were reported to the Secretary for the first calendar quarter of the calendar year in which a determination under subparagraph (A) is made to (II) the average of the taxable wages of all persons for whom wages were reported to the Secretary for the first calendar quarter of 1970; such product, if not a multiple of \$10, shall be rounded to the nearest multiple of \$10, or

"(ii) the exempt amount for each month in the taxable year beginning in the year preceding the year specified in clause (i) of subparagraph (A), or

"(iii) \$150."

(e) The amendments made by this Act shall apply with respect to taxable years ending after December 1969.

○



THE MINIMUM BENEFIT
UNDER
OLD-AGE AND SURVIVORS INSURANCE

* * *

A REPORT ON A STUDY CALLED FOR BY
PUBLIC LAW 761, 83rd CONGRESS

Department of Health, Education, and Welfare
Washington: 1955



Introduction

Public Law 761, the Social Security Act Amendments of 1954, contains the following section calling for a study of the minimum benefits under the old-age and survivors insurance program:

"Sec. 404. (a). The Secretary of Health, Education, and Welfare shall conduct a full and complete study with a view to determining the feasibility of increasing the minimum old-age insurance benefit under Title II of the Social Security Act to (1) \$55 per month, (2) \$60 per month, and (3) \$75 per month.

"(b) Such study shall include (1) a detailed analysis of the estimated increase in cost, if any, involved in increasing such minimum benefit to each of the above referred to amounts, (2) estimates of the financial impact such increase would have upon the Old-Age and Survivors Insurance Trust Fund, and (3) an estimate of the amount, if any, by which Federal grants to the States for public assistance would be reduced by reason of such increase in minimum old-age insurance benefits.

"(c) The Secretary shall report to the Congress at the earliest practicable date the results of the study provided for by this section."

In accordance with this directive the Department of Health, Education, and Welfare has conducted a study of the feasibility of increasing the minimum benefit to the specified amounts. This report sets forth the findings of the study.

Scope of the study

Subsection (b) of sec. 404 requires that the study include an analysis of the estimated increase in the cost of the old-age and survivors insurance program that would result from the proposed benefit increases, estimates of the impact of those increases on the Federal Old-Age and Survivors Insurance Trust Fund, and estimates of the effect of the increases on Federal grants for public assistance. Accordingly, this report sets forth the Department's findings on each of these questions.

The Department does not believe, however, that the feasibility of the proposed increases in the minimum benefit can be evaluated solely in terms of cost. It believes rather that in order to assess adequately the effect of the increases, attention must also be given to the question of who will benefit from, and who will be worse off as a result of, the consequent increases in costs. The report therefore includes, in addition to the Department's findings on the specific questions enumerated in sec. 404, an analysis of the relationship of the proposed increases to employment patterns, earnings and benefit levels of workers and of beneficiaries with a view to determining who would be helped and who would be hurt by the proposals.

Nature of the OASI program

Old-age and survivors insurance is a program under which individuals pay contributions from their earnings while they are working, and, when earnings are cut off by retirement in old age or by the death of the worker, payments are made to the worker and his dependents or to his survivors. The benefits are related to the past earnings of the worker and the regularity of his work under the program.

Types of benefits.--Monthly benefits are payable under the program, upon retirement of a qualified worker at or after age 65, to: the retired worker, the wife or dependent husband at age 65, the worker's unmarried children under age 18, and his wife at any age while she has such children in her care. Monthly survivors benefits are payable, upon the death of a qualified worker, to: the widow or dependent widower at age 65, the unmarried dependent children under age 18, the widow (and in some cases divorced wife) at any age while she has such children in her care, and dependent parents at age 65 if the worker left no other survivor who could ever qualify for monthly benefits. A lump-sum payment is also payable on the death of a qualified worker. In June 1955 some 6.1 million persons 65 and over and 1.5 million younger widows and children were receiving benefits.

Qualifications for benefits.--Retirement benefits are payable only to persons who are "fully insured" under the system and to their dependents. In the long run a person will need to be in covered employment 10 years to be fully insured at retirement. For the early years, however, in order to make it easier for those already near age 65 when the program went into effect to qualify, a shorter period of work is sufficient. Before the amendments of 1950 an individual was fully insured if he worked in covered employment at least half the time after January 1, 1937, and before reaching age 65, with a minimum of one and one-half years. Now the starting point is January 1, 1951, rather than 1937, and covered work before as well as after that date counts toward meeting the new requirements. The 1954 amendments, which extended the coverage of the program to several million additional persons, included an alternative provision designed to make it easier for persons who were already close to age 65 when first covered by the program on January 1, 1955, to become insured. Under it a person is fully insured if he has earnings credits in each calendar quarter after 1954 and prior to the quarter of death or of attainment of age 65; there must be at least six such quarters. This alternative way of becoming insured will "wash out" by the end of 1958, since at that time the "one-half the time since 1950" requirement will be easier to meet. At the end of 1954 about 70 million people were fully insured under the program.

The 1954 amendments also provide that an individual under 65 who becomes totally disabled (with the disability expected to be of long-continued and indefinite duration) can have his benefit rights "frozen" for as long

as he is unable to work. To be eligible for the "freeze," he must have worked in covered employment at least half the time in the last 10 years before becoming disabled and at least half the time in the last 3 years before becoming disabled. When the worker retires or dies, the period during which he was disabled is disregarded in determining his insured status and the benefit amount payable.

Survivors' benefits for a worker's children and their mother may be paid if the deceased worker was either fully insured or "currently insured," i.e., has at least one and one-half years of covered work within the three years immediately preceding his death.

Retirement test.--For persons under age 72, payment of benefits is conditioned upon substantial retirement. If a person's earnings (whether from covered or noncovered work) for a year are not more than \$1,200, none of his benefits will be suspended because of such earnings. Each \$80 of earnings (or fraction thereof) over \$1,200 will result in withholding of one month's benefit, except that benefits will be paid for any month in which the individual neither rendered substantial services in self-employment nor worked for wages of more than \$80. Persons age 72 and over receive their benefits as annuities, without regard to the amount of their earnings.

Amount of benefits.--The amount of insurance benefit is based on the worker's own earnings in employment covered by the law. The benefit formula provides for paying in benefits a larger proportion of the average earnings of low-paid workers than of higher paid workers. The formula is 55 percent of the first \$110 of average monthly wage plus 20 percent of the next \$240. The average monthly wage, on which benefits are based, is computed in general by dividing the worker's total earnings in covered work by the number of months in which he could have been expected to work under the program. Under the law in effect prior to the 1950 amendments the computation, in general, took into account all months beginning with 1937; under the 1950 amendments, for workers with 6 quarters of coverage after 1950, the computation may start with either 1937 or 1951. Under new provisions adopted in 1954, periods of disability and up to 5 years of low earnings may be omitted from the computation under certain circumstances.

Benefit payments for an individual retired worker now range from a minimum of \$30 a month to a maximum of \$103.50. The maximum will be \$108.50 for those retiring after March 1956. (In order to qualify for \$108.50 an individual must have had covered earnings at the rate of \$4,200 a year since January 1, 1955.) Benefits for dependents and survivors are figured as percentages of the benefit payable to the worker.

The maximum benefits payable for a month to a family on the basis of any one person's record are the lesser of 80 percent of his average monthly earnings or \$200. If family payments as initially figured would total more than either of these amounts, each dependent's benefit is proportionately reduced to bring the total down to the applicable maximum; but application of the 80 percent maximum may not reduce the family benefit below \$50 or one and one-half times the worker's own benefit amount, whichever is larger. The minimum benefit payable on a worker's wage record is \$30.

In December 1954 the average payment for retired workers with no dependents receiving benefits was about \$56.50 monthly; the payment for retired aged couples averaged \$98.50; for widows with two children the average family payment was \$126.

Reflecting the new computation provisions of the 1954 amendments, the benefit awards for persons now coming on the rolls for the first time are considerably higher than those given above for all beneficiaries. Among beneficiaries who came on the rolls in December 1954 and whose benefits are based on earnings after 1950 with years of lowest earnings omitted, the average for a retired worker alone was about \$78 per month; for an aged couple, about \$125; and for a widow with two children, about \$180.

Coverage.--About 9 out of 10 paid civilian jobs are covered by the program--in absolute figures, about 54 million out of a total of 60 million. Because many people change jobs and move in and out of the labor force during the course of a year, a much larger number contribute under the program during a year than are covered at any one time. In 1955 nearly 69 million people are expected to contribute under old-age and survivors insurance. About 8 million of them will be self-employed; the rest will have worked for nearly 5 million employers who also make contributions.

Because the old-age and survivors insurance and railroad retirement systems are coordinated, persons who work in the railroad industry may be said to be covered under both of these systems, and 2.0 million railroad employees are included above as being covered under old-age and survivors insurance. In a sense members of the armed forces are also covered under old-age and survivors insurance, although on a temporary basis; wage credits of \$160 are given under the old-age and survivors insurance system for each month of active service in the armed forces from September 1940 through June 30, 1955, if credit for the same service is not given under another Federal retirement system. Career servicemen will generally receive credit under the retirement systems of the armed forces but not under old-age and survivors insurance. Also included in the above figures are some 4.5 million

jobs in the employ of State and local governments. Only about 1.2 million of the employees in these jobs are already receiving credit under old-age and survivors insurance, but Federal law authorizes the coverage of the rest by agreements between the State and the Federal government.

Employees covered under a State or local retirement system can be brought into old-age and survivors insurance only if a majority vote in favor of old-age and survivors insurance coverage.

The only major groups not under old-age and survivors insurance or eligible for OASI coverage are about 1.8 million Federal employees covered under retirement systems of the Federal government and about 200,000 policemen and firemen covered under State and local retirement systems; about 300,000 self-employed lawyers, dentists, doctors and members of certain medically related professions; and those domestic and agricultural workers who do not earn sufficient wages from any one employer to meet the coverage requirements of the law. The total number of domestic and farm workers not covered varies from around 800,000 to some 2 million, depending on the season of the year. There are also about 1.6 million persons who at any one time are in self-employment but who, usually because of failure to work throughout a given year, do not have net income of as much as \$400 in that year and are therefore not in covered work for that particular year. About 400,000 others--newsboys, members of religious orders, student nurses, and other smaller groups--are also excluded.

Many persons who in a given year do some work in self-employment or perform services as farm or domestic workers and yet do not meet the tests for coverage spend comparatively little time in gainful employment and a considerable number of them are not ordinarily in the labor market. Included in this group are semiretired or partially disabled persons, housewives, and children. Most of the housewives are protected under old-age and survivors insurance through their husbands' employment, and the school children and college students will generally become covered when they enter full-time employment. On the other hand, these groups do include some people who are full-time participants in the labor force but who fail to meet the tests in a particular year.

It should be noted that the coverage of ministers, of employees of nonprofit organizations and of State and local governments, and of certain Americans employed abroad has certain voluntary aspects. The 1954 amendments to the Social Security Act made coverage possible for a substantially increased number of persons in these groups, but the extent to which they will elect coverage is not yet known.

How the system is financed.--Benefits are financed by contributions of covered employees and employers and self-employed persons. Each year an amount equal to 100 percent of the taxes collected is automatically

appropriated to the Federal Old-Age and Survivors Insurance Trust Fund. The money in the fund can be used only to pay the benefits and administrative expenses of the program. Money not needed to meet current payments is invested in interest-bearing obligations of the United States.

Contributions are a percentage of the first \$4,200 earned in a year. The contribution rate, currently 2 percent each for employer and employee, is scheduled to increase in a series of step-ups to 4 percent each in 1975. The rate for self-employed persons is $1\frac{1}{2}$ times the employee rate. The contribution schedule is designed to make the insurance system self-supporting.

Contributions under old-age and survivors insurance during the calendar year 1954 totalled \$5.2 billion and benefit payments totalled \$3.7 billion, of which \$3.0 billion was for aged persons. At the end of 1954 the trust fund amounted to about \$20.6 billion.

Description of the specific proposals considered

In order to make the study called for by section 404 two minor assumptions were made as to how the proposed minimum provisions would operate. First, it was assumed that the proposed increases in the minimum benefits would be effective for July 1955 (variations of several months, however, would have little effect on cost from a long-range standpoint). Second, it was assumed that the proposed minimum amounts would be applicable not only to the benefit payable to the retired worker and to the amount on which dependents' and survivors' benefits are based, but also as the benefit payable to a single survivor beneficiary. (The 1954 amendments provide that a single survivor beneficiary, such as an aged widow or parent, shall receive the same minimum payment as a retired worker--\$30.)

Specifically, then, the proposals considered in the study were as follows:

The minimum amount payable to a retired worker,
the minimum amount payable when only one survivor is entitled
to benefits on a given wage record, and
the minimum amount on which a dependent's or survivor's
benefits would be based--
would be \$55
\$60, or
\$75.

All other provisions would remain unchanged.

Effect of the Proposals on Cost and Financing
of Old-Age and Survivors Insurance

The estimates of the effects of the proposals on the old-age and survivors insurance program presented in the following paragraph correspond, both in form and in the assumptions on which they are based, to those presented in the Fifteenth Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund (Senate Document No. 39, 84th Congress, 1st Session). The Social Security Act requires the Board of Trustees to report annually to the Congress on the expected operations and status of the trust fund during the next five years and on the actuarial status of the fund; and accordingly the Trustees' Report presents short-range and long-range cost estimates separately. That practice has been followed here also. Detailed information on the bases underlying the estimates that follow can be obtained from the Trustees' Report.

Short-range effects ^{1/}

Table 1 shows, for the years 1955 through 1960, the estimated amount of benefit payments under present law and the estimated increases in benefit payments resulting from each of the proposed higher minima. It will be noted that, for each full year of payments at the higher amounts, with the \$55 minimum benefit payments would be increased by about \$600 million; with the \$60 minimum, by about \$800 million; and with the \$75 minimum, by about \$1.7 billion.

Table 2 presents detailed estimates of the expected operations and status of the trust fund over the years 1955 through 1960 under the present law and with the proposed higher minima. The contribution income is of course assumed to be the same under present law and under each of the proposals, as are the administrative expenses. Because benefit payments increase, the interest income to the fund decreases with the decreasing size of the funds available for investment.

The aggregate increase in the fund over the six-year period is considerably larger under present law than it would be under the proposed minima. At the end of 1954 the trust fund amounted to \$20,576 million. The aggregate net increase in the fund in the years 1955-60 under present law is expected to be about \$8 billion. Under a \$55 minimum it would be \$4.6 billion and with a \$60 minimum it would be \$3.4 billion. With a \$75 minimum disbursements would exceed income in four of the six years and there would be a net decrease in the size of the fund of \$1.9 billion.

^{1/} The short-range estimates are based on the assumption of a continuance of a relatively high level of economic activity, as explained in the Fifteenth Annual Trustees' Report, p. 14, in the description of "Alternative I."

Table 1.—Estimated amount of benefit payments under present law and increase in benefit payments resulting from proposed higher minima, 1955–1960.¹

(in millions)

Calendar year	Present law	Increase in benefit payments resulting from raising the minimum to:		
		\$55	\$60	\$75
1955	\$4,980	\$226	\$307	\$ 651
1956	5,681	591	800	1,703
1957	6,233	601	816	1,744
1958	6,718	600	814	1,746
1959	7,175	590	800	1,727
1960	7,618	571	775	1,685

¹Increases in minimum assumed to be effective July 1, 1955.

Note: Estimates based on assumption of a relatively high level of economic activity as described in the Fifteenth Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund, p. 14, under "Alternative I."

Table 2.—Expected operations of the trust fund under present law
and with proposed higher minima, 1955–1960.¹
(in millions)

Calendar year	Transactions during period					Fund at end of period
	Income		Disbursements		Net increase in fund	
	Contribu- tions	Interest on investments	Benefit payments	Administra- tive expenses		
	Present law					
1955	\$5,595	\$474	\$4,980	\$113	\$ 976	\$21,552
1956	6,454	498	5,681	122	1,149	22,701
1957	7,001	523	6,233	124	1,167	23,868
1958	7,385	747	6,718	118	1,096	24,964
1959	7,726	569	7,175	116	1,004	25,968
1960	9,715	609	7,618	117	2,589	28,557
	Minimum of \$55					
1955	5,595	471	5,206	113	747	21,323
1956	6,454	486	6,272	122	546	21,869
1957	7,001	497	6,834	124	540	22,409
1958	7,385	508	7,318	118	457	22,866
1959	7,726	515	7,765	116	360	23,226
1960	9,715	541	8,189	117	1,950	25,176
	Minimum of \$60					
1955	5,595	470	5,287	113	665	21,241
1956	6,454	483	6,481	122	333	21,574
1957	7,001	488	7,049	124	316	21,890
1958	7,385	494	7,532	118	229	22,119
1959	7,726	496	7,975	116	131	22,250
1960	9,715	517	8,393	117	1,722	23,972
	Minimum of \$75					
1955	5,595	466	5,631	113	317	20,893
1956	6,454	463	7,384	122	-589	20,304
1957	7,001	449	7,977	124	-651	19,653
1958	7,385	433	8,464	118	-764	18,889
1959	7,726	413	8,902	116	-879	18,010
1960	9,715	411	9,303	117	706	18,716

¹Increases in minimum assumed to be effective July 1, 1955.

Note: Estimates based on assumption of a relatively high level of economic activity as described in the Fifteenth Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund, p. 14, under "Alternative I."

Long-range effects 1/

Table 3 shows estimates of benefit payments under present law and of the increases that would result from the proposed higher minima, for specified years in the future. It will be noted that by the year 2020, with a \$55 minimum, benefit payments would increase by \$2.3 billion per year; with a \$60 minimum, by \$3.2 billion; and with a \$75 minimum, by about \$6.2 billion.

1/ It is of course impossible to make exact predictions of conditions that will exist in the distant future. Estimates of the future cost of the old-age and survivors insurance program, however, are affected by such conditions, and assumptions must be made about what those conditions will be. The assumptions used in the actuarial cost estimates may differ widely and yet be reasonable. Accordingly, it has been the practice to prepare both a low-cost and a high-cost estimate combining different assumptions as to low and high rates of mortality and other cost factors. The result is, of course, a range of possible costs. Congressional committees have adopted the practice of relating the contribution rates to the mid-point between the high and low cost estimates--the so-called "intermediate cost" basis. All of the estimates presented in this section are developed on the "intermediate cost" basis.

The estimates are based on the long-range cost estimates for the present system as contained in the Fifteenth Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund (Senate Doc. No. 39, 84th Congress) and as given in more detail in Actuarial Study No. 39 of the Social Security Administration. Since the cost estimates for the proposals to increase the minimum benefit were made, new long-range cost estimates have been prepared for the present law on the basis of revised earnings assumptions. These estimates are briefly summarized in the report of the Committee on Ways and Means of the House of Representatives on H.R. 7225 (House Report No. 1189, 84th Congress). The new cost estimates show a somewhat lower level-premium cost for the present program than that shown in the Fifteenth Trustees' Report--7.51 percent of payroll as compared with 7.70 percent. Since use of the new, lower cost estimates would not affect the conclusions reached in this report, the cost figures have not been recalculated on the new basis.

The estimates are based also on an assumption of continued high employment and take account of the coordination with the railroad retirement program provided for under present law, as described in Appendix I of the Fifteenth Annual Trustees' Report.

Table 3.--Estimates of benefit payments under present law and increase in benefit payments resulting from proposed higher minima for specified future years.
(in millions)

Calendar year	Present law	Increase in benefit payments resulting from raising the minimum to		
		\$55	\$60	\$75
1970	\$11,377	\$ 874	\$1,222	\$2,535
1980	15,285	986	1,469	3,231
2000	20,014	1,682	2,365	4,693
2020	26,064	2,296	3,192	6,180

Note: Intermediate estimate based on assumption of continued high employment.

Table 4 presents long-range estimates of the expected balances in the trust fund under present law and with the proposed higher minima. Under present law the fund is expected to build up gradually from its present size of about \$21 billion to almost \$63 billion in 1990, after which it is expected to decrease slightly to a little over \$60 billion in 2000. With a minimum of \$55 the fund would build up very slowly to a high of \$31 billion in 1980; thereafter it would decrease over the next 18 years and would be exhausted in the year 1998. With a \$60 minimum the fund would be stabilized at approximately its present size through the year 1980, after which it would decrease, becoming exhausted in 1991. With a \$75 minimum the fund would begin to decrease almost immediately and would be exhausted in 1970.

Table 4.--Estimates of balance in trust fund under present law and with the proposed higher minima for specified future years.
(in millions)

Calendar year	Present law	Trust fund assets at end of year under proposed increases in minimum to		
		\$55	\$60	\$75
1965	\$29,919	\$23,098	\$20,104	\$9,345
1970	35,114	23,465	18,414	<u>3/</u>
1975	44,018	26,627	19,056	
1980	55,573	31,393	20,641	
1990	62,910	20,411	1,334	
2000	60,494	<u>1/</u>	<u>2/</u>	

1/ Fund exhausted in 1998.

2/ Fund exhausted in 1991.

3/ Fund exhausted in 1970.

Note: Intermediate estimate based on assumption of continued high employment and 2.4 percent interest.

Table 5 shows long-range estimates of cost under present law and with the proposed higher minima, expressed as a percent of taxable payroll, and the level-premium cost. 1/

1/ The "level-premium cost" may be defined as the contribution rate, chargeable from a given date such as the effective date of the proposed increases, that, together with interest (including that from existing funds on hand), would meet into perpetuity the cost of all benefit payments and administrative expenses arising under the program. The schedule of contribution rates in the law starts out considerably lower than the level-premium rate and ends somewhat above it.

Table 5.--Estimates of cost under present law and with proposed higher minima, expressed as a percent of taxable payroll for specified future years.

Calendar year	Present law	Proposed increase in minimum to		
		\$55	\$60	\$75
		<u>Benefit cost in year</u>		
1970	5.98	6.43	6.62	7.31
1980	7.34	7.81	8.04	8.89
2000	8.22	8.91	9.20	10.15
2020	9.63	10.47	10.80	11.91
		<u>Level-premium cost 1/</u>		
	7.70	8.32	8.59	9.50

1/ Level-premium contribution rate, assuming interest at 2.4 percent, for benefit payments after 1954 taking into account interest on the existing trust fund on December 31, 1954, future administrative expenses, and the lower contribution rates payable by the self-employed.

Note: Intermediate estimate based on assumption of continued high employment.

As indicated in the table, the level-premium cost under present law is expected to amount to about 7.7 percent of payroll. The level-premium cost of increasing the minimum to \$55 would be about 0.6 percent of payroll. For \$60 and \$75 minima, corresponding figures are 0.9 percent and 1.8 percent. These figures indicate the immediate increases in the combined employer-employee contribution rates that would be necessary, if the minimum were raised to the proposed amounts, to maintain the system in the same financial balance that now exists.

The Effect on Federal Grants to States for Public Assistance

Relationship of public assistance to old-age and survivors insurance

In order to assess adequately the effect of the proposals on Federal grants to States for public assistance, attention must be directed to the present relationship between the public assistance and old-age and survivors insurance programs.

Insurance beneficiaries may receive public assistance if their benefits and other income do not meet their need according to the standards set by the assistance agency in the State where they live. (They must, of course, also meet the other eligibility requirements set by the agency.) The number of aged and child beneficiaries of old-age and survivors insurance who also receive public assistance payments, together with the amounts of benefits and assistance, are determined once each year on the basis of a sample of the assistance recipients in each State. In February 1955, about 489,000 recipients of old-age assistance and 32,100 families receiving aid to dependent children were receiving benefits under the old-age and survivors insurance program (table 6). These totals represented more than 19 percent of all old-age assistance recipients and somewhat more than 5 percent of the families receiving aid to dependent children. In relation to the total number of aged OASI beneficiaries, the proportion receiving supplemental old-age assistance payments was less than 9 percent. Of the families with children that receive OASI benefits, slightly under 5 percent received supplementary assistance under the aid to dependent children program.

Extended coverage and liberalized benefits under old-age and survivors insurance since 1950 have resulted in a decline of the proportion of the aged in the population receiving assistance. In 1950 there were more aged people receiving old-age assistance than old-age and survivors insurance benefits. Today aged old-age and survivors insurance beneficiaries are more than twice as numerous as aged assistance recipients. In 1950 about 23 percent of the aged received assistance; today the percentage is 18. With present widespread coverage of employment by old-age and survivors insurance it may be anticipated that with the passage of time more of the recipients of old-age assistance will also be beneficiaries of old-age and survivors insurance. By the end of 1960 it is estimated that about 845,000 recipients, or 35 percent of the total old-age assistance load, will be beneficiaries of old-age and survivors insurance.

In analyzing the effect of the proposed increases in the minimum benefits on the public assistance programs, attention was concentrated on the effect of the proposals on old-age assistance recipients and expenditures in their behalf at the present time and at the end of 1960. The old-age and survivors insurance program affects the aid to dependent children program only to a limited extent. Children deprived of care or support because of the death, absence, or incapacity of a parent are aided under

Table 6.--Aged persons and families with children receiving both OASI benefits and assistance payments, 1948-55.

Month and year	Aged persons receiving both OASI and OAA		Families with children receiving both OASI and ADC		
	Number	Percent of		Number	Percent of
		Aged OASI beneficiaries	OAA recipients		
June 1948	146,000	10.0	6.1	21,600	6.7
September 1950	276,200	12.6	9.8	32,300	8.3
August 1951	376,500	11.9	13.8	30,700	6.7
February 1952	406,000	12.0	15.1	30,000	6.1
February 1953	426,500	10.7	16.3	30,600	5.7
February 1954	463,000	9.7	18.0	31,900 ¹	5.4
February 1955	488,800	8.7	19.2	32,100	4.9
					ADC families
					4.8
					4.9
					5.0
					5.0
					5.3
					5.9
					5.2

¹Data on ADC-OASI families are for November 1953; OASI families for February 1954.

the assistance program. Only 1 ADC family in 6 receives assistance because of the death of the father. Among these families with father dead about a fourth (5.2 percent of all ADC families) receive old-age and survivors insurance benefits. Increases in the number of families with insurance benefits have resulted in fewer families with father dead coming on the rolls. The part of the ADC load that would be affected by increases in OASI minima is already so small that the increases would have little effect on expenditures for the program.

Present aged persons receiving both OASI and OAA - State differences

Table 7 shows the extent of concurrent receipt of old-age and survivors insurance benefits and assistance payments by old-age assistance recipients in February 1955. Examination of the table indicates that the proportion of recipients of old-age assistance who also received insurance benefits ranged from 41 percent in Nevada to 2 percent in Alabama. In 10 States, chiefly in the South, the proportion of aged recipients with benefits was less than one-tenth. The 12 States in which at least one-fourth of the recipients of old-age assistance also get insurance benefits were located either in the Northeast or the West.

The proportion of old-age and survivors insurance beneficiaries who receive assistance to supplement their incomes also varies widely among States. In 34 States less than one-tenth of the aged beneficiaries received assistance, with Virginia having the smallest proportion--slightly over 1 percent. In 7 States more than one-fifth needed supplementary assistance. In Louisiana more than two-fifths of the aged beneficiaries received old-age assistance.

Future aged persons receiving both OASI and OAA - differences in size of benefits

Effects of the proposed increases in minimum OASI benefits were estimated from distributions of old-age assistance payment amounts and the amounts of old-age and survivors insurance benefits obtained in the 1953 sample study of old-age assistance recipients. These estimates were adjusted both for benefit increases resulting from the 1954 amendments and for the estimated number of concurrent beneficiaries of assistance and insurance on the basis of reports submitted by all States in February 1955. The 1960 estimates were based on estimated distributions of insurance beneficiaries by benefit amounts for that year. Two assumptions were made in determining the effect of the proposals on the old-age assistance program in 1960. First, it was assumed that the same proportion of beneficiaries at each benefit level would receive old-age assistance to supplement their incomes as received supplementation in 1954. Second, it was assumed that the proportion of concurrent recipients who are married to other beneficiary recipients would be the same (one-fourth) in 1960 as at the present time.

Table 7.—Concurrent receipt of OASI benefits and assistance payments by OAA recipients, February 1955.

State	Persons receiving OAA and OASI as percent of:	
	OAA recipients	OASI beneficiaries
Total	19.2	8.7
Alabama	2.4	2.3
Alaska	29.9	21.9
Arizona	21.8	13.4
Arkansas	6.1	7.1
California	36.7	20.8
Colorado	26.9	28.3
Connecticut	32.6	5.2
Delaware	14.7	1.8
District of Columbia	20.8	3.0
Florida	23.8	10.9
Georgia	8.5	12.5
Hawaii	15.7	2.6
Idaho	23.2	11.4
Illinois	19.3	5.3
Indiana	17.7	4.0
Iowa	17.6	8.3
Kansas	16.1	8.6
Kentucky	9.8	7.0
Louisiana	19.1	42.1
Maine	27.9	7.1
Maryland	16.1	2.2
Massachusetts	35.7	12.5
Michigan	24.3	7.5
Minnesota	17.1	8.5
Mississippi	6.0	12.4
Missouri	23.3	20.8
Montana	20.9	9.8
Nebraska	15.5	6.8
Nevada	41.2	20.2
New Hampshire	24.9	5.2
New Jersey	23.0	2.1
New Mexico	11.6	13.0
New York	25.8	3.9
North Carolina	7.6	5.3
North Dakota	11.0	8.7
Ohio	20.6	6.2
Oklahoma	15.7	26.0
Oregon	30.1	7.9
Pennsylvania	15.9	1.9
Rhode Island	28.5	5.3
South Carolina	5.1	6.4
South Dakota	13.1	9.5
Tennessee	6.7	6.3
Texas	12.4	16.8
Utah	18.0	9.0
Vermont	23.7	9.6
Virginia	5.3	1.1
Washington	29.9	16.0
West Virginia	4.9	1.8
Wisconsin	21.7	6.6
Wyoming	25.8	14.2
Puerto Rico	—	—
Virgin Islands	—	—

While the proportion of beneficiaries with minimum benefits receiving old-age assistance to supplement their income was assumed to be the same in 1960 as at the present time, the number receiving assistance will be smaller since fewer beneficiaries will be getting minimum benefits at that time (table 8). About 30 percent of the recipients with no spouse (or with a spouse not receiving old-age assistance) will be receiving the minimum benefit of \$30 as compared with 37 percent in February 1955. About 81 percent (as compared with 86 percent in February 1955) will be receiving less than \$55; about 86 percent (as compared with 91 percent in February 1955) will be receiving less than \$60; and about 95 percent (as compared with 98 percent in February 1955) will be receiving less than \$75.

Minimum benefits to a retired worker and spouse at age 65 under the proposed minima of \$55, \$60, and \$75 were presumed to be one and one-half times the minimum for a retired worker, or \$82.50, \$90.00, and \$112.50. Looking at the figures in the table for couples, both of whom receive an old-age assistance payment, we find that in 1960, 22 percent will be receiving the minimum benefit of \$45, the present minimum for a retired worker and his spouse, as compared with 27 percent in February 1955. The proportion with benefits of less than \$82.50 and \$90 will also be smaller in 1960 than in February 1955. Practically all recipients will be receiving benefits of less than \$112.50. As time goes on the proportions at the lower amounts will of course continue to decrease.

Most of the aged insurance beneficiaries who receive old-age assistance have low benefits. In February 1955 the average benefit payment for all aged beneficiaries was \$54.83 as compared with \$38.79 for the group receiving old-age assistance. Recipients who have relatively high benefits are usually individuals with high medical needs or have other unusual expenses. As already indicated, a smaller proportion of persons in concurrent receipt of old-age and survivors insurance benefits and assistance payments will be getting low benefits as time goes on. A great many of the present small benefits result from the payment of benefits on the basis of as few as 6 quarters (roughly 18 months) of coverage in the years after 1936 and before 1950; gaps in coverage in those years lower the average on which the benefits are based. The "new start" beginning in 1951 for computing average monthly wage, the exclusion of periods of disability and up to 5 years of low earnings in the average wage computation, and substantially universal coverage will result in smaller numbers of beneficiaries being awarded benefits of less than the proposed minima (at least at the \$55 and \$60 levels) in the future. The increase in the amount of future old-age and survivors insurance benefits that will occur tends to reduce the effect on old-age assistance payments in future years that the proposed minima would otherwise have.

Table 8.—Estimated percentage distribution of old-age assistance recipients with OASI benefits, by amount of benefit received under existing law.

Old-age insurance benefit amount	February 1955	End of 1960
<u>Recipients with no spouse or with spouse not receiving OAA</u>		
Total number	368,000	698,000
Total percent	100	100
\$30.00	37	30
30.10-54.90	48	51
55.00-59.90	5	5
60.00-74.90	8	10
75.00-108.50	2	5
Under \$55.00	86	81
Under \$60.00	91	86
Under \$75.00	98	95
<u>Recipients with spouse also receiving OAA¹ (total OASI benefits to both)</u>		
Total number	121,000	147,000
Total percent	100	100
\$45.00	27	22
45.10-82.40	47	47
82.50-89.90	8	8
90.00-112.40	19	23
112.50 and over	²	²
Under \$82.50	74	69
Under \$90.00	81	77
Under \$112.50	99	99

¹Percentage distribution is based on total recipients, including both husband and wife.

²Less than 0.5 percent.

Effect of proposals on OAA cases and costs

Tables 9 and 10 show the estimated effect on recipients of old-age assistance and on total and Federal expenditures in their behalf of the proposals to increase the minimum old-age and survivors insurance benefit. The estimates assume that no provisions of the OASI title other than the minimum would be affected, i.e., that the minimum benefits to a retired worker and spouse would be one and one-half times the minimum for a retired worker, and that benefits at or above the proposed minima would be unchanged.

It should be noted that within the \$55 minimum the single or widowed recipients would receive a maximum benefit increase of \$25 and that those whose present benefits are between \$30 and \$55 would receive less than this amount. Since most persons receiving assistance to supplement insurance benefits get payments in excess of \$25 (the average assistance payment to concurrent beneficiaries in February 1955 was \$40.95), a \$55 minimum would result in many reductions in assistance payments but in a reduction of only 67,000 recipients as of February 1955 and 107,000 by the end of 1960. These closings represent 14 and 13 percent, respectively, of the estimated numbers of concurrent beneficiaries under present legislation. At the \$60 and \$75 levels the number of closings would increase. Even at the \$75 level, however, only about 44 percent of the concurrent recipients (8 and 15 percent of the total old-age assistance loads in February 1955 and at the end of 1960) would have their assistance payments discontinued.

With the total number of concurrent beneficiaries increasing and the number with benefits of less than the proposed minima decreasing, a smaller proportion of the concurrent beneficiaries would be affected by the proposed minima in the future.

Federal financial aid is available to States only within stated dollar maximums on individual assistance payments. In the old-age assistance program, the Federal government now shares in individual assistance payments up to \$55 a month. The Federal share is four-fifths of the first \$25 (on an average basis) and one-half of the remainder up to \$55 for each individual. Immediate savings in Federal funds expended for old-age assistance would amount to more than 4 percent if a \$55 minimum were adopted and to 10 percent if a minimum were set at \$75. In 1960, because of the expected increase in the number of concurrent beneficiaries--35 percent of the total old-age assistance load as compared with 19 percent at the present time--the proportionate amount in Federal savings would be larger. If a \$55 minimum were adopted, the savings in Federal funds expended in 1960 would amount to 8 percent; if a \$75 minimum were adopted, the 1960 Federal savings would amount to somewhat less than 19 percent.

Table 9.—Estimated effect on old-age assistance caseloads and costs if minimum old-age and survivors insurance benefits are increased.

Estimated effect on:	If minimum old-age insurance monthly benefit is increased to:		
	\$55	\$60	\$75
<u>February 1955</u>			
<u>Cases</u>			
Total concurrent beneficiaries ¹	489,000	489,000	489,000
Number closed	67,000	101,000	217,000
Number reduced	337,000	331,000	265,000
Number not reduced.	85,000	57,000	7,000
<u>Annual expenditures</u>			
Will reduce			
Total ²	\$73,000,000	\$91,000,000	\$143,000,000
Federal.	41,000,000	53,000,000	90,000,000
<u>End of 1960</u>			
<u>Cases</u>			
Total concurrent beneficiaries. . . .	845,000	845,000	845,000
Number closed	107,000	162,000	371,000
Number reduced	558,000	549,000	441,000
Number not reduced.	180,000	134,000	33,000
<u>Annual expenditures</u>			
Will reduce			
Total ²	\$116,000,000	\$148,000,000	\$237,000,000
Federal.	65,000,000	86,000,000	150,000,000

¹Based on reports submitted by all States in February 1955.

²Federal, State and Local.

Table 10.—Percentage distribution of estimated effect on old-age assistance caseloads if minimum old-age and survivors insurance benefits are increased.

Estimated effect on cases	If minimum old-age insurance monthly benefit is increased to:		
	\$55	\$60	\$75
<u>February 1955</u>			
Total number of concurrent beneficiaries	489,000	489,000	489,000
Total percent ¹	100	100	100
Percent closed	14	21	44
Percent reduced	69	68	54
Percent not reduced	17	12	1
<u>End of 1960</u>			
Total number of concurrent beneficiaries	845,000	845,000	845,000
Total percent	100	100	100
Percent closed	13	19	44
Percent reduced	66	65	52
Percent not reduced	21	16	4

¹Totals do not necessarily equal the sum of rounded components.

It is interesting to compare the estimated savings under old-age assistance with the estimates of increased benefit payments under old-age and survivors insurance. ^{1/} Comparisons of table 1 with table 9 indicate that if the minimum benefit were raised to \$55, total savings--Federal, State and local--under old-age assistance at 1955 levels would be \$73 million and Federal savings would be \$41 million, as compared with an increase in old-age and survivors insurance payments of \$226 million. If the minimum were increased to \$75, total old-age assistance costs would be reduced by \$143 million, the Federal share of assistance cost would be reduced by \$90 million, and old-age and survivors insurance payments would be increased by \$651 million.

The differences are even more marked if figures for 1960 are compared. Estimated reductions in old-age assistance expenditures for 1960, if the minimum were increased to \$55, are \$116 million for total reductions and \$65 million for reductions in the Federal share, while benefit payments under old-age and survivors insurance would increase by \$571 million. If the minimum were raised to \$75, total reductions in old-age assistance would be \$237 million and the reduction in the Federal share would be \$150 million, while increases under old-age and survivors insurance would amount to \$1,685 million.

^{1/} In the sentences that follow, the figures for old-age assistance and those for old-age and survivors insurance are not strictly comparable since the latter include increase in cost attributable to payments to young widows and children as well as to persons aged 65 and over, while the savings in aid to dependent children are not included in the assistance figures. The savings in aid to dependent children, however, as has been indicated, are not significant.

Major Questions to be Considered

The old-age and survivors insurance program partially replaces earnings for individuals (and their families) when those earnings are interrupted by retirement or death. Since workers at low income levels are less able than higher-paid workers to reduce their standard of living, benefits are a greater proportion of their earnings than of the earnings of the high-paid workers. This "weighting" in the benefit formula is necessary to make it possible for workers with low earnings to buy the basic necessities of life without at the same time paying higher-paid wage earners much larger benefits than at present and thus greatly increasing the cost of the system. Under the present formula a worker whose average monthly wage is \$110 or less receives 55 percent of his average monthly wage in benefits, whereas an individual whose average monthly wage is \$350 receives only 31 percent of it in benefits.

Under this formula, at wage levels now prevailing in the United States, practically all regular and full-time workers will receive benefits considerably above the present \$30 minimum. Those earning \$100 a month will get \$55 on retirement; a couple with the husband earning \$100 will get \$82.50. Even if earnings are only \$80 a month, a single retired person will get \$44 and a couple \$66. The function of the minimum, therefore, generally speaking, is not to raise benefits for full-time workers at low wages.

Moreover, the 1954 amendments introduced provisions into the law that protect the benefit levels of workers who become permanently and totally disabled; and in addition up to five years of no earnings or low earnings may be disregarded in arriving at the average monthly wage. These and other provisions designed to improve the benefit amounts paid under the program are described in more detail below. As a result of these provisions, the minimum provision will not generally function to raise the benefits of the permanently and totally disabled or the benefits of those normally full-time workers who may have spells of unemployment or part-time work at some periods of their lives.

The first major question to be considered by the Congress in deciding whether or not the minimum should be increased is therefore: Who would benefit from such an increase?

As has been indicated in the section of this report on costs, the proposed increases in the minimum would substantially increase the costs of the program and would therefore require an increase in the contribution rates if the program were to remain self-supporting. The higher contribution rates would of course be paid by all covered workers, most of whom qualify for benefits above the proposed amounts and would therefore receive no benefit increases.

A second major question to be considered, then, is: Who would lose by the proposed increases by reason of bearing increased costs without receiving any increase in protection in return?

With these questions as background we may proceed to an examination of the benefits payable under the program, now and in the future, and of the earnings records on which benefits will be based.

An Analysis of Benefits

An obvious first question to be answered by an examination of the benefit rolls of the program is, What are people receiving in benefits now? More specifically, how many and who among those now on the benefit rolls would have their benefits increased if the proposed higher minimum benefits were adopted? Present benefit rolls have been analyzed to throw light on this question. But because changes in the provisions of the program in the last few years will greatly change the picture for the future, we must also look ahead, and therefore estimates have been prepared of what the beneficiary rolls will be like in 1960. (The analysis of earnings that follows the benefit analysis will indicate the effect of the proposed increases in the minimum over the long-run future, as well as more specifically the groups that will be affected.) Moreover, in examining both present and future benefit experience we will find it necessary to consider men and women separately because the characteristic work patterns of men and women are quite different.

In the analysis that follows attention is concentrated on the effect of the proposals on aged beneficiaries. It is of course important that young survivor families be adequately provided for under the program. At present, however, only one out of eight of all beneficiary families are young survivor families, and they receive only one out of every six dollars of benefit payments; in the future even these small proportions will decrease considerably. Similarly, among the aged beneficiaries, individuals receiving benefits as the dependent parents of deceased wage earners have not been considered because they form so small a proportion--at present less than one-half of one percent--of the total.

Benefits to retired workers

Table 11 shows retired worker beneficiaries receiving benefits at the end of 1954 distributed by benefit amount and by sex. Table 12 shows the distribution of the same group by benefit amount and by region and State. The tables indicate that about 17 percent of the nearly 4 million retired-worker beneficiaries on the rolls at the end of the year were receiving the minimum benefit of \$30. If the minimum were increased to \$55, about 44 percent of the total would have their benefits increased; if the minimum were \$60, about 50 percent would receive an increase; if the minimum were \$75, almost 75 percent would have their benefits increased. (The maximum payable in 1954 was \$98.50.)

In the Northeast only 13 percent of the beneficiaries now receive the minimum benefit, while in the South nearly 25 percent do so. The Middle West and Far West fall pretty close to the average for the country. The same relationships among the regions hold at the higher levels, too. While 37 percent of the beneficiaries in the Northeast region receive less than \$55, about 54 percent of those in the South and 43 percent and 46 percent in the Middle West and Far West respectively, receive less than \$55.

Table 11.—Estimated percentage distribution of old-age benefits¹ in current-payment status at the end of 1954 by amount of monthly benefit and sex of beneficiary.

Old-age benefit amount			
	Total	Male	Female
Total number	3,732,000	2,803,000	929,000
Total percent ²	100	100	100
\$30.00	17	13	28
30.10–54.90	27	23	37
55.00–59.90	7	7	7
60.00–74.90	24	25	20
75.00–98.50	26	32	8
Under \$55.00	43	36	66
Under \$60.00	50	43	72
Under \$75.00	74	68	92

¹Includes aged wife's benefit amounts payable to women concurrently receiving old-age benefits.
Excludes women concurrently receiving an aged widow's benefit.

²Totals do not necessarily equal sum of rounded components.

Table 12.--Number and average monthly amount of old-age benefits in current-payment status and percentage distribution by amount of benefit, by Region and State, December 31, 1954.
(Percentage distribution based on 10-percent sample)

Region and State	Average old-age benefit	Number of beneficiaries	Total	Percent of old-age beneficiaries receiving:									
				\$30.00	\$30.10— 54.90	\$55.00— 59.90	\$60.00— 74.90	\$75.00— 98.50	Under \$55.00	Under \$60.00	Under \$75.00		
Total¹	\$59.14	3,775,134	100.0	16.9	26.6	6.8	23.9	25.9	43.4	50.2	74.1		
Northeast	62.11	1,243,486	100.0	13.3	23.7	7.0	26.8	29.2	37.0	44.0	70.8		
Connecticut	65.57	67,828	100.0	10.7	20.0	6.4	26.8	36.1	30.7	37.1	63.9		
Maine	55.25	34,019	100.0	21.1	28.6	8.0	24.2	18.1	49.7	57.7	81.9		
Massachusetts	62.36	171,693	100.0	12.2	23.4	7.1	29.0	28.3	35.6	42.7	71.7		
New Hampshire	57.50	21,240	100.0	14.6	28.9	8.6	27.2	20.7	43.5	52.1	79.3		
New Jersey	64.09	148,921	100.0	12.8	21.8	6.4	25.3	33.7	34.6	41.0	66.3		
New York	61.36	454,068	100.0	14.0	24.9	7.0	26.0	28.1	38.9	45.9	71.9		
Pennsylvania	62.72	304,784	100.0	12.8	22.7	6.9	27.7	29.9	35.5	42.4	70.1		
Rhode Island	61.63	29,410	100.0	12.4	22.7	8.3	29.5	27.1	35.1	43.4	72.9		
Vermont	55.88	11,523	100.0	19.1	28.2	8.0	23.1	21.6	47.3	55.3	78.4		
South	53.93	778,799	100.0	24.8	29.2	6.5	21.3	18.2	54.0	60.5	81.8		
Alabama	51.55	43,696	100.0	27.7	30.4	7.0	20.9	14.0	58.1	65.1	86.0		
Arkansas	48.58	31,389	100.0	32.6	31.1	6.6	18.1	11.6	63.7	70.3	88.4		
Delaware	59.67	8,840	100.0	19.4	24.7	6.2	23.5	26.2	44.1	50.3	73.8		
District of Columbia	57.73	14,838	100.0	15.9	29.4	7.3	24.4	23.0	45.3	52.6	77.0		
Florida	59.44	103,682	100.0	19.5	24.9	6.0	21.7	27.9	44.4	50.4	72.1		
Georgia	50.60	45,041	100.0	29.1	32.9	5.7	18.4	13.9	62.0	67.7	86.1		
Kentucky	53.95	51,757	100.0	23.8	29.4	7.0	22.6	17.2	53.2	60.2	82.8		
Louisiana	51.54	36,739	100.0	26.8	32.3	6.6	18.2	16.1	59.1	65.7	83.9		
Maryland	58.03	50,987	100.0	18.2	27.2	6.5	24.5	23.6	45.4	51.9	76.4		
Mississippi	47.19	23,010	100.0	35.3	31.5	5.7	17.5	10.0	66.8	72.5	90.0		
North Carolina	52.11	48,855	100.0	26.3	30.3	7.7	22.2	13.5	56.6	64.3	86.5		
Oklahoma	52.62	39,331	100.0	26.9	29.8	5.4	21.2	16.7	56.7	62.1	83.3		
South Carolina	51.98	22,947	100.0	25.8	31.5	7.1	21.2	14.4	57.3	64.4	85.6		
Tennessee	50.93	48,172	100.0	28.5	32.4	6.6	19.7	12.8	60.9	67.5	87.2		
Texas	52.67	111,706	100.0	27.1	29.9	6.1	19.0	17.9	57.0	63.1	82.1		
Virginia	54.53	54,447	100.0	23.0	29.0	6.4	23.3	18.2	52.0	58.4	81.7		
West Virginia	58.81	43,362	100.0	18.9	23.4	7.2	27.9	22.6	42.3	49.5	77.4		

Table 12.-- Continued

Region and State	Average old-age benefit	Number of beneficiaries	Total	Percent of old-age beneficiaries receiving:										Under \$55.00	Under \$60.00	Under \$75.00
				\$30.00	\$30.10— 54.90	\$55.00— 59.90	\$60.00— 74.90	\$75.00— 98.50								
Middle West	\$59.99	1,140,213	100.0	17.9	25.0	6.2	22.8	28.1				42.9	49.1	71.9		
Illinois	61.94	234,248	100.0	15.1	23.4	6.6	24.2	30.7				38.5	45.1	69.3		
Indiana	58.31	109,812	100.0	19.8	26.3	6.1	22.1	25.7				46.1	52.2	74.3		
Iowa	54.60	60,349	100.0	24.7	28.5	6.0	21.9	18.9				53.2	59.2	81.1		
Kansas	54.06	43,083	100.0	24.1	30.9	6.2	21.0	17.8				55.0	61.2	82.2		
Michigan	64.37	158,548	100.0	13.8	22.4	6.3	21.5	36.0				36.2	42.5	64.0		
Minnesota	57.41	71,118	100.0	21.2	27.1	6.1	22.0	23.6				48.3	54.4	76.4		
Missouri	56.62	100,633	100.0	20.8	27.9	6.8	22.9	21.6				48.7	55.5	78.4		
Nebraska	53.69	27,765	100.0	24.5	29.0	5.1	22.8	18.6				53.5	58.6	81.4		
North Dakota	50.57	7,389	100.0	30.9	30.6	5.3	18.7	14.5				61.5	66.8	85.5		
Ohio	62.20	221,887	100.0	14.9	23.5	6.2	23.7	31.7				38.4	44.6	68.3		
South Dakota	52.14	10,505	100.0	25.8	30.7	6.0	23.4	14.1				56.5	62.5	85.9		
Wisconsin	59.73	94,876	100.0	19.7	24.1	5.4	22.1	28.7				43.8	49.2	71.3		
Far West	58.36	568,559	100.0	18.3	27.6	7.2	22.8	24.1				45.9	53.1	75.9		
Arizona	58.19	15,322	100.0	23.1	25.6	6.8	20.1	24.4				48.7	55.5	75.6		
California	58.73	334,555	100.0	17.0	28.0	7.2	23.1	24.7				45.0	52.2	75.3		
Colorado	56.43	31,609	100.0	23.4	25.4	7.6	22.2	21.4				48.8	56.4	78.6		
Idaho	53.62	12,649	100.0	24.5	30.7	5.5	20.4	18.9				55.2	60.7	81.1		
Montana	55.75	13,800	100.0	24.1	28.3	6.0	22.6	19.0				52.4	58.4	81.0		
Nevada	56.70	4,146	100.0	21.5	31.5	6.2	21.8	19.0				53.0	59.2	81.0		
New Mexico	52.24	7,596	100.0	29.2	28.1	5.9	16.7	20.1				57.3	63.2	79.9		
Oregon	58.51	53,242	100.0	18.2	27.6	7.4	22.9	23.9				45.8	53.2	76.1		
Utah	58.18	12,339	100.0	20.6	25.6	5.7	22.1	26.0				46.2	51.9	74.0		
Washington	59.52	77,986	100.0	15.9	26.5	8.1	24.1	25.4				42.4	50.5	74.6		
Wyoming	56.49	5,315	100.0	24.6	25.2	6.9	22.0	21.3				49.8	56.7	78.7		
Alaska	56.15	1,960	100.0	19.4	26.4	8.3	22.9	23.0				45.8	54.1	77.0		
Hawaii	56.49	8,111	100.0	19.9	29.0	6.8	21.3	23.0				48.9	55.7	77.0		
Puerto Rico	40.71	10,173	100.0	33.6	48.6	2.6	11.8	3.4				82.2	84.8	96.6		
Virgin Islands ²	42.11	160	100.0	—	—	—	—	—				—	—	—		
Foreign	62.07	23,673	100.0	10.6	21.6	7.9	35.0	24.9				32.2	40.1	75.1		

¹Percent distribution of total reflects adjustment (estimated) to include the amount of aged wife's benefits payable to women concurrently receiving old-age benefits and to exclude women concurrently receiving aged widow's benefit. Percent distributions for individual States were not adjusted because of lack of data.

²Too few cases in sample for a reliable distribution.

Differences between States are even greater, as might be expected. In Connecticut, for example, only 11 percent now receive the \$30 minimum, about 31 percent get less than \$55, 37 percent less than \$60, and 60 percent less than \$75. In Mississippi, at the other extreme, 35 percent now get the minimum, 67 percent get less than \$55, 72 percent less than \$60, and 90 percent less than \$75. In Puerto Rico we find almost 34 percent of the beneficiaries at the minimum, 82 percent below \$55, 85 percent below \$60 and almost 97 percent below \$75.

Table 11 shows the distribution of benefit amounts by sex. It is extremely important to consider separately the experience of men and women under the old-age and survivors insurance program because of differences in the character of the normal work experience of men and of women. Almost all men are full-time workers. They enter the labor market when they finish school and, except for periods of unemployment and disability, work consistently throughout their lives. Their wage patterns may vary with occupation or with geographical location, but overall they are in the labor market through their adult years. Their families normally are dependent upon their earnings for support.

Among women who work, on the other hand, most do not follow this pattern. Large numbers work before marriage but leave the labor market while their children are young. They may or may not return to work when their children are grown. A large percentage of women who work have part-time jobs. While the work of women is important to the economic security of their families, the great majority of them are not consistently dependent upon their own earnings for their full support.

We would expect, then, to find benefits for men under the program considerably higher than for women, and table 11 shows this to be true. Of the 3,732,000 retired workers on the benefit rolls at the end of 1954, 2,803,000, or roughly three-quarters, were men. About 13 percent of the men were receiving the \$30 minimum, as compared with 28 percent of the women. About 36 percent of the men, as compared with about 66 percent of the women, were receiving less than \$55; 43 percent of the men, as compared with 72 percent of the women, were receiving under \$60; and 68 percent of the men, as compared with 92 percent of the women, were getting less than \$75. Thus the benefits payable to women reflect their more casual attachment to the labor force and their lesser participation in the program.

Even for men, the distribution of benefit payments for those on the rolls at the end of 1954 does not reflect full-time earnings at present earnings levels. The benefits now being paid reflect employment at earnings levels much lower than now prevail, periods of work outside of covered employment, and periods of disability and unemployment. All of these factors have operated in the past to dilute the average monthly wage and the benefits based thereon.

For most people who become beneficiaries in the future, on the other hand, the situation will be very different. In recent years several amendments to the law have been adopted to protect the average monthly wage and benefit amount of persons who are normally dependent on their own earnings but who, because of circumstances beyond their control, either fail to have covered earnings during certain periods or have covered earnings lower than those typical of their full earning capacity.

First, the coverage of the program has been made very nearly universal. Prior to 1950 major areas of work were outside of the coverage of the program--work in agriculture and domestic service, urban self-employment, employment by Federal, State and local governments and nonprofit organizations. The only major areas that still remain excluded in 1955 are Federal employment already under a retirement system and self-employment in certain professions. Of particular importance is the extension of coverage to both self-employment and wage employment in agriculture that was accomplished by the 1950 and 1954 amendments. The large numbers of people now getting low benefits in rural areas is chiefly a reflection of the fact that because part of their time was spent in farm work, only part of their earnings were covered and creditable toward benefits.

The second amendment in the law that will improve average monthly wages and benefit amounts of those coming on the rolls in the future is the "new start" adopted in 1950. Under this provision most retired workers coming on the rolls in the future will have their benefits based only on earnings after 1950, so that the relatively low wages of the late thirties and forties will not operate to depress their average monthly wages and benefit amounts.

The third such amendment is the provision for the "drop-out" adopted in 1954, under which as much as five years of low earnings, may be disregarded in determining the average monthly wage. This provision will permit the exclusion of periods of temporary unemployment, apprentice earnings, or "tapering off" toward retirement, so that an individual who by and large has worked throughout his life and supported himself may receive benefits based on an average not far below that of his full-time earnings. Finally, the provision adopted in 1954 for "freezing" the benefit amounts of workers who become permanently and totally disabled will mean that such workers, if they have been substantially attached to the work force before incurring their disabilities, will be able to receive full-rate benefits when they reach retirement age.

The effect of all these provisions will be to pay higher benefits to many of the people who otherwise would have gotten benefits at or near the minimum. In general, the changes listed will provide higher benefits for those who normally support themselves and their families but who under prior law would have had gaps in their earnings records because of non-covered work, unemployment, or disability or who would have had periods

of low earnings counted against them. The changes listed will generally not increase benefits to any considerable extent for those whose work over their lifetimes is only part-time or intermittent. As a result of the changes, therefore, the effect of the present \$30 minimum will be limited, in the future, largely to raising benefits for part-time and intermittent workers.

Let us look, then, at the situation as it may be in the future--in 1960, for example. Table 13 shows retired worker beneficiaries in current-payment status at the end of 1960 distributed by benefit amount and by sex. The table indicates that about 10 percent of the retired workers then on the rolls will be receiving the minimum benefit of \$30, as compared with 17 percent at the end of 1954. About 30 percent (as compared with 43 percent in 1954) will be receiving less than \$55; about 35 percent (as compared with about 50 percent in 1954) will be receiving less than \$60; and about 57 percent (as compared with 74 percent in 1954) will be receiving less than \$75. Looking at the figures for men we find that 22 percent (as compared with 36 percent in 1954) will be receiving less than \$55; about 26 percent (as compared with 43 percent in 1954) will be receiving less than \$60; and 46 percent (as compared with 68 percent in 1954) will be getting less than \$75.

These figures of course reflect the fact that retired workers coming on the rolls over the next five years will generally be entitled to higher benefits than people who have already retired. In order to indicate what the picture will look like for those retiring in the future, estimates have been prepared of benefits to be awarded to retired workers over the next few years. Tables 14 and 15 present percentage distributions of those benefits by benefit amount, sex of beneficiary, and starting date for computing the average monthly wage.

Table 14 shows much smaller proportions receiving benefits at the lower levels than were shown for those now on the rolls. Only about one-fifth of the benefits awarded are expected to be below \$55, about one-fourth below \$60, and less than one-half (about 43 percent) below \$75.

Here again it is important to note how the experience of men differs from that of women. Among the male workers coming on the rolls in the next 6 years, about 12 percent would receive less than \$55, as compared with about 42 percent for women; about one-seventh would qualify for less than \$60, as compared with about one-half of the women; and less than one-third of the men (30 percent) would qualify for less than \$75, as compared with about four-fifths of the women.

The most significant information contained in the table, however, is the difference in the distribution of benefits based on earnings after 1936 and those based only on earnings after 1950. The latter reflect the effects of the changes in the program listed above; benefits based on

Table 13.—Estimated percentage distribution of old-age benefits¹ in current-payment status at the end of 1960, by amount of monthly benefits and sex of beneficiary.

Old-age benefit amount			
	Total	Male	Female
Total number	5,978,000	4,292,000	1,686,000
Total percent ²	100	100	100
\$30.00	10	7	17
30.10–54.90	20	14	35
55.00–59.90	5	4	6
60.00–74.90	21	20	26
75.00–108.50	43	54	16
Under \$55.00	30	22	52
Under \$60.00	35	26	59
Under \$75.00	57	46	84

¹Includes aged wife's benefit amounts payable to women concurrently receiving old-age benefits.
Excludes women concurrently receiving widow's benefits.

²Totals do not necessarily equal the sum of rounded components.

Table 14.--Estimated percentage distribution of old-age benefits¹ awarded in 1955-60 by amount of monthly benefit, by computation method and by sex of beneficiary.²

Old-age benefit amount	Total			Male			Female		
	Total	Based on earnings after 1936	Based on earnings after 1950	Total	Based on earnings after 1936	Based on earnings after 1950	Total	Based on earnings after 1936	Based on earnings after 1950
Total ³	100	100	100	100	100	100	100	100	100
\$30.00	5	12	3	3	9	2	9	16	5
30.10-54.90	15	36	8	9	28	3	33	50	25
55.00-59.90	4	10	2	2	9	1	6	12	4
60.00-74.90	20	27	17	16	32	12	30	18	35
75.00-108.50	57	15	70	70	22	82	22	3	31
Under \$55.00	20	48	11	12	37	5	42	66	30
Under \$60.00	23	57	12	14	46	6	49	78	34
Under \$75.00	43	85	30	30	78	18	78	97	69

¹Includes aged wife's benefit amounts payable to women concurrently receiving old-age benefits. Excludes women concurrently receiving an aged widow's benefit.

²Beneficiaries eligible for drop-out of up to 5 years of lowest earnings in calculation of average monthly wage.

³Totals do not necessarily equal the sum of rounded components.

Table 15.—Estimated percentage distribution of old-age benefits awarded
in 1955–60 by computation method and by sex of beneficiary.¹

Computation method	Total	Male	Female
Total	100	100	100
Benefits based on:			
Earnings after 1936	24	20	33
Earnings after 1950	76	80	67

¹Beneficiaries eligible for drop-out of up to 5 years of lowest earnings in calculation of average monthly wage.

earnings after 1936 generally will not reflect all of those changes. In general, an individual may qualify for a computation based on earnings after 1950 if he has 6 quarters of coverage after 1950. Even if he does qualify he may nevertheless have his benefit computation based on earnings after 1936 if that would be more favorable. A computation based on earnings after 1936 would generally be more favorable only if he had very little covered work after 1950. The benefits based on earnings after 1950, therefore, include practically all benefits awarded to individuals who have been dependent on recent covered work. Those whose benefits will be based on earnings over the entire period since 1936 will be those who have been out of covered work after 1950, either because of sickness or disability, work in noncovered jobs, or periods in which the individual was not dependent on his own earnings.

Among the benefits based on earnings after 1950, only about 11 percent will be below \$55, about 12 percent below \$60, and about 30 percent below \$75. Among the men whose benefits will be based on earnings after 1950--and this group is the one that includes the regular full-time long-term workers who support themselves and their families through earnings in covered work--only about 1 in 20 will be receiving less than \$55, only 1 in 16 less than \$60 and fewer than 1 in 5 (18 percent) less than \$75.

Who are these few who would receive less than the specified amounts? Even among this group we can assume that while some of those qualifying for benefits at the low levels may be people employed full time in covered work, most are people who work only part of the time in covered jobs. Even though coverage is very nearly universal there are still some areas of work outside of the program. Thus among the men whose benefits will be based on earnings after 1950 the 1 person in 20 who qualifies for less than \$55 may be, for example, a self-employed lawyer or a Federal employee who picks up enough part-time work to qualify. (He needs only 40 calendar quarters with \$50 in covered wages in each quarter, or 10 years with covered self-employment income of \$400 in each year, to do so.) Even if coverage is extended as widely as possible there would still be people--for example, State and local government employees whose employers had not brought them into coverage, or even a person living on income from investments--who would not be under the program for the major part of their lives but who could pick up enough covered work to become insured. The expense of paying the high minimum benefits to people with this kind of work history would of course have to be borne by the people covered under the program for a full working lifetime.

We can conclude, then, from our analysis so far that among beneficiaries coming on the rolls in the future the regular full-time, lifetime workers who have supported themselves and their families over their lifetimes by working in covered jobs would generally not be helped by the proposed increases. While a few regular, long-time workers might be helped, particularly with a \$75 minimum (this is discussed more specifically in

the earnings analysis that follows), the very great majority would be hurt because they would have to pay increased contributions without any increase in protection. The increased contributions would chiefly go to pay high benefits to people--self-employed doctors and lawyers, Federal workers, and investors--who were not dependent on earnings from covered jobs and who contributed to the program for only a small fraction of their lives.

Women as beneficiaries under the program

This report has already touched on the fact that women workers generally qualify for lower benefits than men. Even among retired women workers coming on the rolls in the future with benefits based on earnings after 1950, we find that about one-third will qualify for benefits of less than \$55 or \$60 and 69 percent for benefits of less than \$75 (table 14). It is important to examine the reasons why women qualify for benefits at these low levels and what can be expected in the future.

Many of the women who qualify for benefits under the program will of course do so as the wives or widows of insured workers rather than in their own right on the basis of their own earnings. Moreover, some will qualify for benefits in more than one of these ways. In the analysis that follows we will consider first the benefits payable to those who qualify only in their own right as retired workers; then we will consider those who qualify as wives or widows on their husbands' earnings records, including those who qualify also in their own right.

Before examining the benefit experience of women under the program, however, it is essential to consider in more detail the work pattern that is customary for women. The great majority of women workers are not primarily dependent on their own wages and salaries for support over the years that for a man would constitute a working lifetime. Only 7 percent of the women aged 65 to 74 have never been married. Thus it can be assumed that over 90 percent of all women, by the time they attain age 65, will have been at some time or another at least partly dependent on the income of their husbands. About 8 out of 10 of these women will have borne children and had the responsibility for their care. While 80 percent of all single women 18 to 65 years old worked in 1950, only 37 percent of the married women, and only one-fourth of the married women with children under 6 years of age, were working. Only 9 percent of the women with some employment covered by old-age and survivors insurance in the period 1937-51 who were aged 35 and over in 1951 had worked under the program in each of the 15 years. In contrast, despite the limited coverage of the program and the fact that the period included World War II when men in this age group were subject to the draft, 24 percent of the corresponding group of men worked in covered jobs in each of the 15 years.

Apparently a common pattern for married women is to work before marriage and then to leave the labor force upon marriage or when the first child is born. Many women return to gainful employment, probably in their late thirties, for a period of some 10 years or more; many withdraw from employment 10 years or so before reaching age 65. Women following this pattern will be insured at age 65 on their own earnings records, but they will have participated in the program for only a fraction of their working lifetimes.

It should be noted, too, that many women will be able to acquire insured status on the basis of part-time employment. While in 1953 about 42 percent of all women aged 14 and over were in the labor force, about 60 percent of the women working in that year were not full-time workers. ^{1/} Eligibility for OASI benefits is based on quarters of coverage; in general, a quarter of coverage is earned if wages of \$50 or more are paid to the individual in the quarter. It is quite possible, therefore, to qualify for benefits on the basis of part-time jobs, even for those who work for only a few years. Thus we will find that as the program matures more and more women will qualify for benefits based on their own employment and earnings records. Some 38 percent of all the aged women beneficiaries in 1960, we estimate, will be receiving benefits based on their own work records; by the year 2000 it is expected that the comparable figure will be around 60 percent.

Let us consider first the women who are qualified only for a benefit in their own right--who are not eligible for benefits as either wives or widows of insured male workers. In the year 1960 it is expected that 24 percent of the aged women beneficiaries will fall in this group.

At present many of the women who qualify for benefits in their own right, but not as wives or widows of insured workers, are married women who have been primarily supported by their husbands' earnings rather than their own but whose husbands failed to become insured. In the short run this could happen because of the limited coverage in the early years of the program, because of long-term disability occurring too early for insured status to be protected under the disability "freeze," or because the husbands had died before the program started.

Over the long run, on the other hand, it may be assumed that most of the women who do not become eligible as wives or widows will have been dependent on their own earnings over a substantial proportion of their lives. Most of those who have so supported themselves can be assumed to qualify for benefits at or above the proposed minima. (The women who qualify for benefits in their own right at amounts below the proposed minima will be found, generally speaking, among the groups who have been

^{1/} U.S. Census, Series P-50, No. 54, Table B.

dependent on their husbands' earnings.) Increasing the minimum to the specified amounts will generally not, then, except in the short run, increase the benefits payable to women who customarily work and support themselves; increases in the minimum are not required for this purpose nor would they have this result.

Turning now to the group of women who are eligible for benefits as wives of retired insured workers, let us consider first the benefits payable to the wives of insured workers who are not eligible for benefits in their own right. In 1960 this group is expected to make up about 30 percent of the total.

As has been explained, a wife is entitled to a benefit amounting to one-half of the old-age benefit payable to her husband. Thus if the minimum benefit payable under the program to a retired worker were \$55, the minimum payable to a wife would be \$27.50 and the amount payable to the family would be \$82.50; if the minimum benefit were \$60, the wife's benefit would be \$30 and the family benefit would be \$90; if the minimum were \$75; the wife's benefit would be \$37.50 and the family benefit \$112.50.

Table 16 shows the percentage distribution by size of family benefit of families consisting of a retired worker and wife in current-payment status at the end of 1954 and at the end of 1960. ^{1/} The table indicates that in 1954, 30 percent of the wives were in families that received less than \$82.50, 36 percent were in families that received less than \$90, and 62 percent were in families that received less than \$112.50.

Among women eligible for wives' benefits, however, the situation is changing fairly rapidly. Women who come on the rolls as wives in the future will generally be eligible on the basis of earnings records of men who will have worked in covered jobs in recent years at the relatively high wage levels prevalent in those years and under the relatively more favorable provisions of the amended law. Thus we find that in 1960 only about one-sixth of the wives will be in families receiving less than \$82.50, one-fifth will be in families receiving less than \$90, and fewer than two-fifths will be in families receiving less than \$112.50.

Let us consider next those women getting wives' benefits who qualify also as retired workers in their own right. We find that in 1960 this group is expected to make up about 5 percent of the total number of aged women

^{1/} Included in the figures are payments to families consisting of a retired woman worker and her dependent husband as well as those consisting of a retired male worker and his wife. Families consisting of a woman worker and dependent husband make up less than 1 percent of the total. Not included are families where the wife is also receiving benefits as a retired worker; they are treated separately in this report.

Table 16.--Estimated percentage distribution of retired worker and aged spouse families¹ in current-payment status at the end of 1954 and 1960 by intervals of family benefit.

Amount of family benefit	December 31, 1954	December 31, 1960
Total families	937,000	1,485,000
Total percent ²	100	100
\$45.00	11	5
45.10-82.40	19	11
82.50-89.90	6	3
90.00-112.40	26	18
112.50-162.80	38 ³	62
Under \$82.50	30	16
Under \$90.00	36	19
Under \$112.50	62	38

¹Excludes families in which the spouse is concurrently receiving old-age benefits.

²Totals do not necessarily equal the sum of rounded components.

³The maximum retired-worker-and-spouse family benefit at the end of 1954 was \$147.80.

beneficiaries. The group can be expected to be made up predominantly of women who have not been dependent on their own earnings over most of their lifetimes and who have spent relatively short periods in covered work. The benefits payable to them as wives will in most cases not be increased as a result of the proposed increases in the minimum since the very great majority of the men will have benefit amounts above the proposed minima. On the other hand, the benefits payable to them in their own right as retired workers can be expected to be relatively low, since they will have worked in covered jobs for relatively short periods, and therefore many of them probably would receive higher benefits as retired workers if the proposed increases were adopted.

We may conclude, then, that one effect of the proposed increases would be to pay higher benefits to families where the wife had been primarily supported by her husband, had had very little covered work, and had paid very small amounts in contributions.

Turning now to the group who are eligible for benefits as the widows of deceased insured workers, let us consider first the group who are eligible for benefits also in their own right. Here the provision in the 1954 amendments for the payment of at least a full minimum benefit to a beneficiary who is the sole survivor entitled to benefits on a given wage record comes into play; whether or not a widow is entitled to a benefit in her own right as a retired worker, the minimum-benefit amount will apply. Thus under present law every woman eligible for a widow's benefit, whether or not she is eligible also for a benefit in her own right, is eligible for at least \$30, even though this may be more than three-fourths of her deceased husband's primary insurance amount. Similarly, if the minimum benefit were increased to \$55, it is assumed that every widow would get at least \$55 even though her husband's primary insurance amount may have been less than \$73.30 (the amount that would produce a widow's benefit of \$55 under the provision that a widow get three-fourths of her husband's primary insurance amount). Thus the fact that a widow becomes eligible for a benefit based on her own work record will not result in her qualifying for a higher minimum amount than she would get as a widow. The effect of the proposed increases in the minimum on the benefit amounts that would be payable to this group may therefore be analyzed by considering only the benefits payable to them as widows.

We have therefore combined the group of women receiving benefits both as widows and as retired workers with the group receiving widow's benefits only. In 1960 the combined groups will amount to 38 percent of all aged women beneficiaries. Table 17 shows the percentage distribution of widow's benefits in current-payment status at the end of 1954 and at the end of 1960. ^{1/} The table indicates roughly the effect of the proposed increases

^{1/} Included in the figures are payments to dependent widowers as well as to widows; the widowers make up only less than 0.5 percent of the total.

Table 17.--Estimated percentage distribution of aged widow's or widower's benefits¹ in current-payment status at the end of 1954 and 1960 by amount of benefit.

Amount of benefit	December 31, 1954	December 31, 1960
Total number	640,000	1,300,000
Total percent ²	100	100
\$30.00	11	10
30.10-54.90	58	49
55.00-59.90	12	10
60.00-74.90	19	28
75.00-81.40	--	3
Under \$55.00	69	59
Under \$60.00	81	70
Under \$75.00	100	97

¹Includes old-age benefit amounts payable to women concurrently receiving aged widow's benefits.

²Totals do not necessarily equal the sum of rounded components.

in the minimum among the 640,000 women now receiving widow's benefits and the 1.3 million expected to receive them in 1960. At present about 11 percent receive benefits at the \$30 minimum. About 69 percent receive benefits amounting to less than \$55 and 81 percent less than \$60. Because the maximum payment now made to a widow (based on the maximum old-age benefit of \$98.50 now payable) is \$73.90, all of the 640,000 widows now on the rolls would receive a benefit increase if the minimum were raised to \$75.

Aged widows constitute a unique group under the program because they may come on the rolls many years after the death of the husband. The benefit amount paid to an aged widow, based as it is on her husband's earnings record, may be related to a work experience that occurred some time in the past. Women will be coming on the benefit rolls for some years to come as the widows of men who died before the program was expanded and improved in 1950, 1952, and 1954 and before earnings had risen to present levels. The benefits payable to the aged widow group will therefore not increase as rapidly as will amounts paid to retired workers and their wives. Thus, looking at the column in the table showing benefits payable in 1960 we find 10 percent still at the \$30 minimum, 59 percent under \$55, 70 percent under \$60, and 97 percent under \$75. (The maximum then payable to a widow will be \$81.40.)

Over the long run the aged-widow group, as well as all other beneficiary groups, will benefit from the expanded coverage, the disability freeze, the "drop-out," and the other improvements that have been made in the program over the last few years, and as these provisions gradually make their effects felt the proportions of the widow group who would benefit from the proposed increases will decline. Nevertheless it appears that a fairly substantial group among those who would be benefited by the proposals, at least in the near future, would be made up of aged widows whose husbands had died before the program was improved. If it were felt that benefits for this group should be improved, methods of doing so other than an increase in the minimum benefit could of course be worked out.

Summary of benefit analysis

To summarize, we find from our analysis of benefits that while many of those already on the rolls would benefit from the proposed increases, the groups who would benefit among those coming on the rolls in the future would be widows whose husbands had died prior to the recent improvements in the program; families where the wife had had barely enough covered work to become insured; and people who have spent most of their lives in noncovered work--for example, as self-employed doctors or lawyers or as Federal employees--or who have lived on income from investments. If improvement in the protection afforded to widows whose husbands have already died is considered a desirable objective, it could of course be achieved in some way other than by increasing the minimum. It would not seem necessary, in order to achieve this objective, that higher benefits be provided also for those whose major source of support over their lifetimes was not subject to the taxes that support the program.

On the other hand, the chief groups who would be hurt by the proposed increases, in the sense that they would pay higher contributions without any increase in protection, would be the group of people who will work in covered jobs regularly and consistently throughout their lifetimes in the future and support themselves and their families out of their earnings from covered work.

An Analysis of Earnings Records

The analysis of benefits has provided an indication of the effect of the proposed increases in the minimum over the next 5 or 6 years. This period of 5 or 6 years is not long enough to give a proper perspective of the proposals, however, since old-age and survivors insurance is a long-range program and many of those now covered by it and contributing under it toward their security will not receive benefits for another 40 years. Accordingly, in order to provide an indication of the long-range effect of the proposals, an analysis has also been made of earnings records of men under the program. That analysis throws additional light, too, on the question of the specific groups who would gain from the proposed increases in the minimum and those who would lose by reason of paying higher contributions without getting higher benefits. (An analysis of the earnings records of women would not be similarly meaningful because it is impossible to assume who among the women employed at any given time, or even over some reasonable period, will be the lifetime workers; it can be assumed that practically all of the men will be.)

Estimates of the relative numbers of men now working in covered employment who would gain by an increase in the minimum benefit, and the number who would lose because they would pay higher contributions but would not get higher benefits, should ideally be based upon long-term earnings experience of workers under conditions that are expected to prevail in the future. Because of the recent changes in the law and in the general level of earnings, however, this ideal cannot even approximately be fulfilled. Estimates derived from long-term earnings experience would necessarily be based upon earnings in covered employment since 1937; in making such estimates several problems arise. First, there is no basis for estimating the amount by which past earnings should be increased to allow for past coverage limitations--when the records show that a person was not in covered employment in the past, there is no way of knowing whether or not he was then in employment that is now covered. Second, there is the problem of developing wage inflation factors to apply to past earnings in order to allow for the rising past trend of wages. One difficulty here is the determination of the amount of earnings credits to allow individuals for military service in and after World War II. Third, there is as yet no adequate basis for estimating the amount of earnings increase to allow for the elimination of periods of disability in average earnings computations. Finally, partly due to the problems already mentioned and partly due to the relatively short span of experience under the program, there is no sound basis for estimating the amount by which earnings would need to be adjusted to allow for the drop-out of years of low earnings in computing the average monthly wage.

Taking account of all factors, it appears that a better estimate of the men who will qualify for less than the proposed minima and therefore would gain by the proposed increases, and of those who will qualify for

more than the proposed minima and therefore would pay higher contributions without getting higher benefits, can be made by assuming that present annual earnings of men working full time will be representative of future average earnings. Present levels of earnings are much more likely than past earnings to be representative of future earnings levels. The present broad coverage and the provision for the drop-out years of disability and of low earnings in the average monthly wage computation indicate the use of full-time earnings to approximate future earnings experience. 1/

Accordingly, the analysis that follows is based on earnings in a single year. The basis for the analysis is a one-percent sample of men with wages in covered employment in 1951. 2/ The sample was restricted to those within the age span that will normally be used in computing life-time earnings under the program--ages 22 through 64. Further restrictions were made to exclude from the sample those who clearly could not be presumed to have worked full time over the year. In the first place, a full-time wage earner obviously must have worked in each quarter of the year; therefore all who had less than four quarters of coverage were eliminated. Secondly, negligibly few adult men wage earners outside of agriculture, with its low cash wage but considerable noncash income, and outside of Puerto Rico and the Virgin Islands, very low-wage areas, earn less than \$600 a year; the latter is equivalent to only 30 cents an hour for a person working 40 hours a week for 50 weeks in the year. The sample was therefore further restricted, with respect to nonfarm workers and workers outside of Puerto Rico and the Virgin Islands, to those with earnings of \$536 or more in 1951 (which, after allowing for the general increase in earnings since 1951, is equivalent to present earnings of \$600 a year). For men wage earners in Puerto Rico or the Virgin Islands or covered as agricultural workers in 1951, all those with four quarters of coverage were included in the sample irrespective of the amount of their earnings. The coverage conditions for agricultural wage earners in 1951 insure that almost all of those with four quarters of coverage in that year were genuine full-time workers. On the other hand, despite the exclusions from the sample, it is clear that for industries other than agriculture the sample included many less-than-full-time workers, since there unquestionably are many part-time, irregular or intermittent workers who earn more than \$50 in each quarter and more than \$600 in a year. Finally, earnings were adjusted upward to allow for an increase of about 12 percent in annual earnings since 1951.

1/ There are other factors that should be mentioned. It is likely that the general trend of earnings will be upward--this would have a tendency to make the estimates of those gaining by larger minimum benefits too high. If it is assumed, on the other hand, that wage levels will remain the same as now, the estimates of those gaining would probably be too small because they may not allow enough leeway in all cases for unemployment, disability, and shifting between covered work and the now relatively small areas of noncovered work.

2/ Men with wages who also had covered self-employment income in the year were excluded because it seemed unlikely that they had worked full-time for wages throughout the year.

The analysis indicates that relatively few men could be expected to qualify for old-age benefits below \$55, \$60, or \$75 a month if they earn steadily at present rates. ^{1/} No more than 1 or 2 out of 100 men would qualify for old-age benefits below \$55 or \$60 if they work full time in covered jobs throughout their lifetimes at present wage rates. No more than 10 out of 100 would qualify for old-age benefits of less than \$75.

That is the picture for the country as a whole. Because of differences in rates of earnings among different industries and geographical areas, the proportions of men who would qualify for old-age benefits of less than \$55, \$60, or \$75 vary considerably from industry to industry and from State to State. Table 18 shows that percentage of men, classified by major industry division, who would qualify for old-age benefits of less than \$55, \$60, and \$75 assuming that current annual earnings levels represent lifetime earnings levels. (Estimated median annual wages in 1954 for the groups included in the sample are also shown.)

Very small proportions of the workers whose major job during the year was in mining, contract constructions, manufacturing, public utilities wholesale and retail trade, or finance, insurance, and real estate would qualify for old-age benefits of less than \$55 or \$60 a month. In services 4 or 5 out of 100, and in agriculture 13 to 16 out of 100, would qualify for old-age benefits of less than \$55 or \$60. (In agriculture as many as 2 or 3 out of 100 wage earners would qualify for only the present minimum old-age benefit of \$30.) While a tenth of all men wage earners included in the sample would qualify for old-age benefits of less than \$75, only about a twentieth of the mining and manufacturing workers would do so; but a fifth of the service workers and a half of the farm workers would do so.

It should be pointed out that the farm workers included in these figures are only those covered by the law prior to the 1954 amendments. Except for certain borderline situations, therefore--and, of course, except for forestry and fishing--the 4-quarter workers in this category are those who worked for a single employer for at least 9 or 10 months without a

^{1/} As indicated, the benefit formula provides for an old-age insurance benefit equal to 55 percent of the first \$110 of the average monthly wage plus 20 percent of the remaining \$240. In order to get an old-age insurance benefit of less than \$55 under this formula, a person would have to have average annual earnings of less than \$1,200; to get a benefit of less than \$60, average annual earnings of less than \$1,308; to get a benefit of less than \$75, average annual earnings of less than \$2,196. Average annual earnings of \$660 or less will produce an old-age benefit of \$30 a month.

Table 18.—Estimated percentages of men wage earners qualifying for old-age insurance benefits of less than \$55, \$60, or \$75 on the basis of full-time¹ wages, and median wages in 1954 of men wage earners with full-time¹ employment, by industry division.

Industry division	Total in sample ²	Percent qualifying for old-age benefits ³ of less than:			Median wages 1954
		\$55	\$60	\$75	
Total	211,634	1.6	2.0	9.5	\$4,176
Agriculture, forestry and fishing	2,610	13.2	15.6	49.5	2,211
Mining	7,465	.5	.8	4.5	4,330
Contract construction	18,414	1.7	2.3	10.6	4,303
Manufacturing	98,543	.8	1.0	6.4	4,300
Public utilities	17,063	1.1	1.5	7.2	4,352
Wholesale and retail trade	45,231	2.1	2.6	12.2	3,904
Finance, insurance and real estate	8,126	1.7	2.2	8.5	4,476
Services	14,182	4.2	5.2	19.5	3,615

¹For nonagricultural wage earners, full-time men workers are defined as those with 4 quarters of coverage and \$536 (equals \$600 after being increased by 12 percent, the rise in annual wages from 1951 to 1954) of wages in 1951; for agricultural wage earners, defined as those with 4 quarters of coverage in 1951.

²One-percent sample of men with wages in covered employment in 1951 but without self-employment income, aged 22–64, and working full time as defined in footnote 1 above; excludes workers whose "State" of major job was Puerto Rico or the Virgin Islands or whose industry of major job was private households or "government not elsewhere classified" or was nonclassifiable.

³On the assumption that annual full-time earnings levels represent life-time earning levels.

break. The law as amended in 1954 will cover, in addition, farm work performed by employees who have had a much shorter duration of employment with a single employer, and who may therefore be expected to have, on the whole, less regular employment and lower annual earnings than the farm workers included in the sample. If the sample were drawn from the group including all farm workers now covered who have four quarters of coverage in a year, it may be assumed that the proportions of the group who would benefit by the increased minimum would be higher than shown by the above figures. On the other hand, farm workers receive a substantial part of their remuneration in forms other than cash, yet only their cash wages are covered under the program.

Workers in private households were omitted from the table. Only a very small proportion of male earners perform domestic service in private households--only 708 such workers appeared in the sample. Among this sample group the proportion who would benefit by the increased minimum would be even higher than shown for the farm workers. For this group, too, wages in kind are not covered and cash wages only are used as the basis for the figures given.

The men working outside of agriculture were further analyzed by State and region. Table 19 shows a considerable variation of 1954 median wages by region, and greater variation by State. It also shows a considerable variation by region and State in the proportions of men who would qualify for old-age benefits below \$55, \$60, and \$75. Looking first at the regions, the proportions qualifying for benefits of less than \$55 or \$60 in the South--3 or 4 percent--are more than twice the corresponding proportions in the other three regions. The same relation holds for those qualifying for benefits of less than \$75: while substantially less than a tenth would do so in the Northeast, Middle West and Far West regions, nearly a fifth would do so in the South.

In several States no more than 1 out of 100 men wage earners outside of agriculture could be expected to qualify for old-age benefits of less than \$55, while in Mississippi more than 5 out of 100 could be expected to do so. In Connecticut, Michigan, Ohio, and Alaska less than 5 in 100 could be expected to qualify for old-age benefits of less than \$75, while in Mississippi 36 in 100 could be expected to do so.

Because of the peculiarities of the economy of Puerto Rico and the Virgin Islands--the importance of agricultural employment, seasonality of employment, and so on--relatively fewer men work full time throughout the year in that area than in the rest of the United States. And of the men working full time in Puerto Rico and the Virgin Islands, relatively large numbers would be advantaged by a minimum benefit of \$55, \$60, or \$75 because of the low earnings rates prevailing in the area. A sample of men wage earners in that area with four quarters of coverage indicates that an eighth had annual earnings so low that they would qualify for no more than the present minimum benefit of \$30; half would qualify on the same basis for benefits of as little as \$55 to \$60; and three-quarters would qualify for benefits of no more than \$75.

Table 19.—Estimated percentages of nonfarm men wage earners who would qualify for old-age insurance benefits of less than \$55, \$60, or \$75 on the basis of full-time¹ wages, and median wages in 1954 of men wage earners with full-time¹ employment, by region and State.

Region and State	Total in sample ²	Percent qualifying for old-age benefits ³ of less than:			Median wages 1954
		\$55	\$60	\$75	
Total	212,699	1.4	1.9	9.2	\$4,170
Northeast	69,145	1.0	1.3	7.0	4,233
Connecticut	3,946	.6	.8	4.3	4,423
Maine	1,061	2.3	2.8	14.4	3,314
Massachusetts	7,853	.9	1.1	6.9	4,021
New Hampshire	786	.9	1.1	9.9	3,450
New Jersey	8,571	.9	1.1	6.0	4,416
New York	26,864	1.2	1.4	8.0	4,355
Pennsylvania	18,362	.9	1.2	5.9	4,184
Rhode Island	1,304	.8	1.0	8.8	3,692
Vermont	398	.4	1.0	7.5	3,533
South	49,278	3.0	4.0	18.9	3,466
Alabama	2,918	4.2	5.6	22.5	3,207
Arkansas	1,248	4.5	5.8	29.1	2,929
Delaware	652	.6	1.5	7.4	4,303
District of Columbia	1,429	3.1	3.9	14.2	3,938
Florida	2,982	3.5	4.7	21.2	3,287
Georgia	3,477	3.6	5.0	25.6	2,980
Kentucky	2,581	2.7	3.3	15.3	3,608
Louisiana	2,788	3.2	4.4	21.7	3,462
Maryland	3,332	2.1	2.8	11.5	3,801
Mississippi	1,131	6.1	7.9	36.3	2,686
North Carolina	4,087	3.2	4.0	25.6	2,878
Oklahoma	2,265	2.5	3.0	13.2	3,766
South Carolina	2,018	4.2	5.0	25.0	2,976
Tennessee	3,275	3.4	4.5	21.0	3,347
Texas	8,904	2.0	2.8	13.8	3,920
Virginia	3,535	3.4	4.5	20.3	3,390
West Virginia	2,656	1.6	2.2	8.5	4,064

(Continued next page)

Table 19.— Continued

Region and State	Total in sample ²	Percent qualifying for old-age benefits ³ of less than:			Median wages 1954
		\$55	\$60	\$75	
Middle West	68,165	.9	1.2	5.6	\$4,426
Illinois	15,305	.8	1.1	5.3	4,532
Indiana	6,368	.8	1.1	5.5	4,413
Iowa	2,349	1.7	2.3	8.0	3,926
Kansas	2,001	1.3	1.8	7.8	3,959
Michigan	12,417	.7	.8	3.7	4,629
Minnesota	3,211	1.1	1.3	6.3	4,223
Missouri	5,139	1.4	1.8	9.8	3,965
Nebraska	1,204	1.5	2.2	10.3	3,759
North Dakota	321	2.5	3.4	15.0	3,551
Ohio	14,607	.8	1.0	4.7	4,531
South Dakota	358	.3	.3	7.0	3,636
Wisconsin	4,885	.8	1.0	5.0	4,418
Far West	25,338	1.1	1.3	5.8	4,473
Arizona	789	1.6	1.8	8.1	4,148
California	15,280	1.0	1.2	5.4	4,540
Colorado	1,466	1.0	1.3	7.2	4,087
Idaho	541	.6	.7	6.3	4,221
Montana	586	1.5	1.9	5.8	4,295
Nevada	228	3.1	3.1	8.3	4,312
New Mexico	540	2.6	3.9	14.1	3,981
Oregon	1,901	1.1	1.5	5.9	4,496
Utah	706	.8	1.4	6.5	4,316
Washington	3,014	.9	1.1	4.3	4,565
Wyoming	287	.3	.3	6.3	4,379
Alaska	179	.6	.6	2.2	5,830
Hawaii	594	1.3	1.9	10.1	3,627

¹Full-time men workers are defined as those with 4 quarters of coverage and \$536 (equals \$600 after being increased by 12 percent, the rise in annual wages from 1951 to 1954) of wages in 1951.

²One-percent sample of 1951 men with wages in covered employment but without self-employment income, aged 22-64, and working full time as defined in footnote 1 above; excludes workers whose "State" of major job was Puerto Rico or the Virgin Islands, or was unclassified, or whose industry of major job was private households, farms, or agricultural services.

³On the assumption that annual "full-time" earnings levels represent life-time earnings levels.

⁴No workers in sample.

The picture, of course, is not complete without figures on the self-employed, most of whom are now covered by the program; they constitute about 15 percent of the total coverage. On the other hand, it is not possible on the basis of available data to separate persons self-employed full time from those self-employed part time. A considerable number of those who are self-employed--both farm and nonfarm--in any one year are part-time workers of one kind or another--they may have entered or left self-employment in the course of the year, for example, or have carried on small business enterprises in their spare time. Moreover, the assumption that present annual earnings levels reflect lifetime earnings levels under the program, which can reasonably be made for men who work in covered employment in all four quarters of the year, is not reasonable as applied to the self-employed. This is particularly true of farm operators. Many who are farm operators in a given year work in covered nonfarm jobs over a substantial part of their lifetimes. Farming is a speculative venture and income of individual farms fluctuate greatly from year to year. Farm operators may therefore be able to take more advantage than others of the drop-out of years of low earnings. Self-employed persons who have extremely low earnings in more than one year may leave self-employment and go to work for someone else, where they will earn more.

For all these reasons, benefit estimates based on self-employed earnings for any one year would in all likelihood greatly understate the benefit levels of persons in self-employment in that year and overstate the proportions of those persons who would gain from the proposed minima. Accordingly, such estimates are not presented in this report.

Finally, it should be noted that an analysis of potential benefits based on earnings records will show a smaller proportion of beneficiaries at the lower benefit levels than would be indicated by an analysis of beneficiary rolls. There are several reasons why this is so. In the first place, people with low earnings and low potential benefits are more likely to become beneficiaries, or to become beneficiaries sooner after retirement age, than those with high earnings and high potential benefits. This selectivity is due primarily to the operation of the retirement test. Under this test a worker just qualifying for an old-age benefit of \$55 on the basis of steady earnings at \$1,200 a year, for example, could upon attaining age 65 immediately begin receiving benefits without giving up his job or suffering any diminution in earnings; whereas a worker with a job paying high wages would have to give up earnings much larger than his benefits if he were to begin receiving benefits. Secondly, the disability freeze and the four or five-year drop-out of low earnings may not be sufficient to make up for periods of unemployment or of less than full-time earnings. More important than either of these is the fact that, as has been indicated, an individual whose main occupation is in noncovered work--or even one who lives mainly on income from investments--can qualify for OASI benefits on the basis of 40 quarters of coverage out of a 40-year working lifetime. An individual with this

sort of work history could not be identified in a study of earnings records for a single year--his covered earnings for that year, and the potential benefit assumed to be paid to him eventually, might be relatively high--but actually he would eventually become entitled to a fairly low benefit.

Summary of earnings analysis

To summarize, then, our analysis of earnings has indicated that, as a general rule, a low rate of earnings is not the primary reason why workers qualify for benefits low enough to gain by the proposed minima. The exceptions to this general rule are workers in certain low wage areas, like Puerto Rico, or in certain occupations with low money wages but considerable noncash income, like farming. The main reason for low benefits--and this is of crucial importance in an evaluation of the proposed minima--is part-time or intermittent attachment to covered employment. In the long run a casual attachment to covered work--either because the individual worked in noncovered jobs or because he did not support himself by his own work--will characterize those gaining by the increases in the minimum.

Additional Factors to be Considered

The relation of benefits to earnings

The percentage of average monthly earnings paid in benefits ranges from 55 percent at averages of from \$55 to \$110 to 31 percent at an average of \$350. The minimum benefit of \$30 exceeds 55 percent of average earnings in those cases where the latter are \$54 or less. If the average earnings are \$30 or less, the minimum benefit, of course, represents 100 percent of earnings or higher. An increase in the minimum benefit would increase the range of average earnings at which the benefit amount would exceed 55 percent, 80 percent, or even 100 percent of those earnings, as the following table shows:

Average monthly earnings below which benefit--			
<u>Minimum benefit</u>	<u>Exceeds 55%</u>	<u>Exceeds 80%</u>	<u>Exceeds 100%</u>
\$30	\$ 54.54	\$37.50	\$30.00
55	100.00	68.75	55.00
60	109.09	75.00	60.00
75	136.36	93.75	75.00

This effect of the increased minima would be accentuated in cases where several members of the family are eligible for benefits. In general the law at present limits total family benefits to 80 percent of the worker's average monthly earnings or \$200, whichever is less. There is, however, an exception to this general rule: The maximum does not operate to reduce family benefits below \$50 or one and one-half times the worker's benefit, whichever is higher. Under this provision, with a minimum of \$55 the guaranteed minimum benefit for, say, a man and wife both eligible for benefits would be \$82.50; with a minimum of \$60 the guaranteed family benefit would be \$90; with a minimum of \$75 it would be \$112.50.

In previous sections of this report it has been indicated that many of the people who would get benefits at the proposed minimum levels would be those who have worked in covered jobs only intermittently or for short periods of their lifetimes. There will be some few regular low-paid workers, however--for example, in Puerto Rico and the Virgin Islands and among farm people--who under the proposals would be receiving more in benefits than they had been able to earn through work. Moreover, it is these very people, employed at low wages, who would be able to apply for and receive benefits at age 65 without retiring, since their earnings will be so low that the retirement test of the program will not apply. Thus we would have the anomalous situation of individuals continuing to work after 65 at their regular lifetime jobs while receiving benefits for themselves and their families higher than they had earned in wages while working.

Variable benefits and financing of OASI

Even more important is the narrowing of the range of benefit amounts that would result from the proposals, and the consequent loss of relationship between benefits and contributions. At present, while benefit amounts at the lower levels, because of the weighting in the benefit formula, are higher in relations to the contributions paid than are the benefits at the higher levels, nevertheless in the long run there is a definite variation in benefit amounts according to contributions, with the higher contributors becoming entitled to the higher benefits.

An obvious exception to this rule is that at the minimum individuals receive the same benefit regardless of the amount of their contribution. Any rise in the minimum benefit amount automatically widens the range of earnings and contributions for which the same benefit is paid. It is possible under present law for an individual first covered under the program in 1955 at age 21 to qualify for minimum retirement benefits on the payment of as little as \$45 in contributions. In contrast, the lifetime worker first covered in 1955 at age 21 with earnings high enough to qualify for benefits amounting to \$55 a month would have to pay about \$1,500 in contributions; if he qualified for \$60, he would have to pay between \$1,600 and \$1,700; if he qualified for \$75, he would have to pay about \$2,000. To qualify for the maximum benefit of \$108.50--less than twice as much as the proposed minimum of \$55 and less than half again as much as the proposed minimum of \$75--he would have had to pay contributions of about \$5,600, in comparison with the \$45 that would be required to qualify for the minimum.

An increase in the minimum benefit also increases the disparity between the value of the contributions paid by workers with low average earnings and the actuarial value of the benefits. Table 20 indicates the level-premium cost of the benefits as a percentage of various levels of average wage under present law and under the proposals for increasing the minimum. The percentages shown indicate the contribution rate the individual would have to pay on his earnings over his lifetime in order to cover the cost of the benefits provided on his earnings record. The illustrations are for a single man and a single woman entering the system at age 20 and retiring at age 65.

As has been indicated in the section of this report which deals with the cost of the proposed increases in the minimum, the cost of the program would be increased by from 0.6 to 1.8 percent of payroll, depending on the amount of the minimum. If this increase were to be uniformly applied to contribution rates it would mean ultimate rates for employers and employees under the system of about $4\frac{1}{4}$ percent each for a \$55 minimum; $4\frac{1}{2}$ percent for a \$60 minimum; and 5 percent for a \$75 minimum. Rates for the self-employment would increase proportionately.

Table 21.—Level premium costs of benefits paid in hypothetical cases as percent of assumed level monthly wages, assuming age 20 at entry, retirement at age 65, assumed future improving mortality, $2\frac{1}{4}$ percent interest.

<u>Single Man</u>				
<u>Level Monthly Wage</u>	<u>Present Law</u>	<u>\$55 Minimum</u>	<u>\$60 Minimum</u>	<u>\$75 Minimum</u>
\$ 50	7.92%	13.40%	14.62%	18.28%
150	6.15	6.15	6.15	6.73
250	4.38	4.38	4.38	4.38
350	3.76	3.76	3.76	3.76

<u>Single Woman</u>				
<u>Level Monthly Wage</u>	<u>Present Law</u>	<u>\$55 Minimum</u>	<u>\$60 Minimum</u>	<u>\$75 Minimum</u>
\$ 50	9.53%	16.12%	17.58%	21.98%
150	7.39	7.39	7.39	8.09
250	5.28	5.28	5.28	5.28
350	4.52	4.52	4.52	4.52

It is clear from the table that at the lowest levels of average wage the increases in the contribution rate would not anywhere nearly compensate for the increase in the value of the benefits provided. At the upper levels of average wage, on the other hand, there would be no increase in the value of the benefits even though the contribution rates would be increased. The increase in the contribution rates of the long-term, relatively higher-paid contributors would be used to pay higher benefits to people who had spent only a short time in covered work.

Summary and Conclusion

As has been indicated, the proposed increases in the minimum would result in appreciable increases in the cost of the OASI program. The increase in cost on a level-premium basis for the \$55 minimum would be 0.6 percent of payroll; for the \$60 minimum, 0.9 percent; for the \$75 minimum, 1.8 percent.

With a \$55 minimum the savings in Federal grants to States for old-age assistance would amount to about 4 percent at present and about 8 percent in 1960. The comparable figures for a \$75 minimum would be 10 percent now and somewhat under 19 percent in 1960. The additional expenditures for OASI in 1955 would amount to from 5 to 7 times the reduction in the Federal share of assistance costs; for 1960 from 8 to 11 times.

Those who would benefit from the proposed increases in the minimum, aside from those people now on the rolls, would be widows whose husbands died before the recent improvements in old-age and survivors insurance, families where the wife had barely enough covered work to be insured, and people who had spent most of their lives outside of covered work such as doctors, lawyers, Federal employees, and investors. In addition there would be some regular lifetime workers in low-wage areas, such as Puerto Rico and the Virgin Islands, or in farming, with its low cash wage and considerable remuneration in kind. The chief group that would be hurt by reason of paying additional contributions without any benefit increases would be the regular, full-time, lifetime workers who supported themselves and their families throughout their lives by work in covered jobs.

It would seem very difficult to justify to the long-term contributors to the system, who even under present law receive less in proportion to their contributions than do the short-term contributors, that they must pay still higher contributions to help finance benefit increases for others while not getting additional benefits themselves. Especially would this be true when it is considered that among those who would receive the increased amounts would be self-employed doctors and lawyers, Federal workers, investors and others whose major source of support--income from noncovered work or investments--is not subject to the taxes that support the program.

Thus the provision of high minimum benefits not only would increase the cost of the program but it might also jeopardize the financing of the program by decreasing the willingness of the long-term regular worker to support the system. In the opinion of the Department of Health, Education, and Welfare there are values inherent in the contributory, variable-benefit system that make it most important that no step be taken, however expedient it may seem in the short run, that would weaken the financial basis of the system.

CMS LIBRARY



3 8095 00014802 9